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ABSTRACT

This is the fifth volume in a series of monographs from the Comprehensive Community Mental Health Service for Children and Their Families Program, which currently supports 41 comprehensive system of care sites to meet the needs of children with serious emotional disturbances (SED). This volume examines theories of adult learning, core values, and four key areas (cultural competence, family-professional relationships, systems thinking, and interprofessional education and training), and looks at promising practices that are combining these concepts into a successful sustainable training program. Individual chapters address: (1) changes in treatment and service systems that challenge traditional training approaches; (2) the essential elements and core competencies of practice in a system of care, including cross-cutting competencies; (3) processes and practices for effective preservice and inservice training; (4) North Carolina's Pitt-Edgecombe-Nash Public-Academic-Liaison (PEN-PAL) project that represents a comprehensive approach to training; (5) promising approaches to training in Santa Barbara (California), Vermont, Hawaii, and Houston (Texas); and (6) characteristics of traditional, modified, integrated, and unified partnerships between state agencies, institutions of higher learning, and families and communities. Appendices include lists of training competencies from different systems of care. (Contains 65 references.) (CR)

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Systems of Care
Promising Practices in Children's Mental Health
1998 Series

VOLUME V

PROMISING PRACTICES: TRAINING STRATEGIES FOR SERVING CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE AND THEIR FAMILIES IN A SYSTEM OF CARE

National Technical Assistance Center for Children's Mental Health
Georgetown University

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Authors:

Judith Meyers, Ph.D., National Technical Assistance Center for Children's Mental Health, Georgetown University

Martha Kaufman, M.A., North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Sybil Goldman, M.S.W., National Technical Assistance Center for Children's Mental Health, Georgetown University

Child, Adolescent, and Family Branch
Division of Knowledge Development and Systems Change
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

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U.S. Department of Health and Human Services
Donna Shalala
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Substance Abuse and Mental Health Services Administration
Nelba Chavez
Administrator

Center for Mental Health Services
Bernard S. Arons, *Director*

Division of Knowledge Development and Systems Change
Michael English, *Director*

Child, Adolescent, and Family Branch
Gary De Carolis, *Chief*

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Foreword

It is with great pleasure that we present the first collection of monographs from the *Promising Practices Initiative* of the Comprehensive Community Mental Health Services for Children and Their Families Program. The Comprehensive Community Mental Health Services for Children and Their Families Program is a multi-million dollar grant program that currently supports 41 comprehensive systems of care throughout America, helping to meet the needs of many of the 3.5 to 4 million children with a serious emotional disturbance living in this country. Each one of the seven monographs explores a successful practice in providing effective, coordinated care to children with a serious emotional disturbance and their families.

The 1998 Series marks a turning point in this five-year-old federal effort, which is administered by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. The first generation of five-year grants is about to come to an end, and with that "graduation" comes a responsibility to add to the national knowledge base on how best to support and service the mental health needs of children with serious emotional disturbance. Until the very recent past, these young people have been systematically denied the opportunity to share in the home, community and educational life that their peers often take for granted. Instead, these children have lived lives fraught with separation from family and community, being placed in residential treatment centers or in-patient psychiatric centers, hundreds and even thousands of miles away from their home. For many of these young people, a lack of understanding of their psychopathology, underdeveloped or non-existing community resources, and a sense of frustration of what to do have led to their eventual placement away from home.

The *Promising Practices Initiative* is one small step to ensure that all Americans can have the latest available information about how best to help serve and support these children at home and in their community. Children with serious emotional disturbance utilize many publicly funded systems, including child welfare, juvenile justice, special education, and mental health, and they and their families often face many obstacles to gaining the care they need due to the difficulties and gaps in navigating multiple service systems. Systems of care provide a promising solution for these children and their families by coordinating or integrating the services and supports they need across all of these public service systems.

The information contained within these monographs by and large has been garnered within the original 31 grants of the Comprehensive Community Mental Health Services for Children and Their Families Program. The research was conducted in a manner that mirrored the guiding principles of the systems of care involved so that it was family-driven, community-based, culturally relevant, and inclusive. Methods for information collection included: site visits and focus groups; accessing data gathered by the national program evaluation of all grantees; and numerous interviews of professionals and parents. Family members were included in the research and evaluation processes for all of the monographs. Two of the papers directly address family involvement, and all of the papers dedicate a section to the family's impact on the topic at hand. The research was drawn from the community-based systems of care and much of the research comes from systems of care with *culturally diverse populations.*

The 1998 *Promising Practices* series includes the following volumes:

Volume I - *New Roles for Families in Systems of Care* explores ways in which family members are becoming equal members with service providers and administrators, focusing specifically on two emerging roles: family members as "system of care facilitators" and "family as faculty."

Volume II - *Promising Practices in Family-Provider Collaboration* examines the fundamental challenges and key aspects of success in building collaboration between families and service providers.

Volume III - *The Role of Education in a System of Care: Effectively Serving Children with Emotional or Behavioral Disorders* explores sites that are overcoming obstacles to educating children with a serious emotional disturbance and establishing successful school-based systems of care.

Volume IV - *Promising Practices in Wraparound* identifies the essential elements of wraparound, provides a meta-analysis of the research previously done on the topic, and examines how three sites are turning wraparound into promising practices in their system of care.

Volume V- *Promising Practices: Training Strategies for Serving Children with Serious Emotional Disturbance and Their Families in a System of Care* examines theories of adult learning, core values, and four key areas (cultural competence, family-professional relationships, systems thinking, and inter-professional education and training), and looks at promising practices that are combining these concepts into a successful sustainable training program.

Volume VI- *Promising Practices: Building Collaboration in Systems of Care* explores the importance of collaboration in a system of care focusing on three specific issues: the foundations of collaboration, strategies for implementing the collaborative process, and the results of collaboration.

Volume VII - In *A Compilation of Lessons Learned from the 22 Grantees of the 1997 Comprehensive Community Mental Health Services for Children and Their Families Program*, the grantees themselves share their experiences in five main areas: family involvement/empowerment, cultural competency, systems of care, evaluation, and managed care.

These seven documents are just the beginning of this process. As you read through each paper, you may be left with a sense that some topics you would like to read about are not to be found in this series. We would expect that to happen simply because so many issues need to be addressed. We fully expect this series of documents to become part of the culture of this critical program. If a specific topic isn't here today, look for it tomorrow. In fact, let us know your thoughts on what would be most helpful to you as you go about ensuring that all children have a chance to have their mental health needs met within their home and community.

So, the 1998 *Promising Practices* series is now yours to read, share, discuss, debate, analyze, and utilize. Our hope is that the information contained throughout this Series stretches your thinking and results in your being better able to realize our collective dream that all children, no matter how difficult their disability, can be served in a quality manner within the context of their home and community. COMMUNITIES CAN!

Nelba Chavez, Ph.D.
Administrator
Substance Abuse and Mental Health Services Administration

Bernard Arons, M.D.
Director
Center for Mental Health Services

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The authors would like to acknowledge the contribution of all those who assisted with both the critical thinking that formed the foundation for Volume V: Training Strategies, as well as those who served as reviewers. The work group that met in April 1998 not only helped formulate the ideas, they provided resources and reviewed the work along the way. In addition, several people in North Carolina helped specifically with the review and editing of Chapter 4, on the North Carolina *PEN-PAL* Project. (See Appendix A for a listing of all these individuals.) Thanks to Charles Biss, Chair of the Human Resource Development Committee of the Division of Children, Youth, and Families, National Association of State Mental Health Program Directors, for his role in conducting a national survey of promising training strategies in states. Special thanks to Joan Dodge and Amy Wischmann of the National Technical Assistance Center for Children's Mental Health for their assistance in the final stages of editing.

Executive Summary

How can people best be trained to practice in systems of care? The monograph, *Promising Practices: Training Strategies for Serving Children with Serious Emotional Disturbances and Their Families in a System of Care,* seeks to answer that question by identifying and describing the following: a) the essential elements of practice that are consistent with system-of-care philosophy, provide quality care to children with emotional disturbances and their families, and lead to positive outcomes; b) the core competencies to be incorporated into training; and c) the essential processes needed to sustain training over sufficient time to result in a change in practice. The focus of the document is to articulate a common base of knowledge, skills, values, and attitudes that cuts across all professions and roles, and that ideally should be part of the training for all individuals working in a system of care, no matter the group with which they identify, or the role they occupy. Promising examples of training curricula and strategies at both the preservice and inservice levels are provided.

METHODOLOGY

The information that forms the basis of this work was gathered from several sources that included the following: a thorough review of the literature; a work group consisting of state and local children's mental health administrators, family advocates, and university-based faculty who served as an expert advisory panel; surveys by the Division of Children, Youth, and Families of the National Association of State Mental Health Program Directors, and the Comprehensive Community Mental Health Services for Children and Their Families Program to identify promising practices; telephone interviews and review of written materials from selected sites; and an interdisciplinary work group on *Innovative Training Approaches for Psychologists Working in the Public Sector*, organized by the American Psychological Association's (APA) Committee for Children, Youth and Families, and APA's Division of Children, Youth and Family Services.

FRAMEWORK

The comprehensive perspective on training presented in the report is based on an ecological and developmental framework that encompasses the principles and values of systems of care. Three important themes served as a foundation for this framework:

1) The purpose of training is to influence practice, yet training is only one of many elements that lead to effective practice; therefore, it cannot be viewed in isolation. The ability to transfer the learning that occurs in training is dependent on many factors in the environment in which a

person works, such as supervisory support, opportunity to use the training, and organizational goals and commitment.

2) Training is a set of interacting events that affect what a person learns, knows, and can do. One has to consider all aspects of this system in developing an approach to training, including the characteristics of the person being trained, the training itself, the environmental or organizational context in which the pe.son works, and standard-setting or credentialing that confirms that competence has been attained or maintained.

3) Effective training is a lifelong process, not a series of one-time events.

CHANGES IN SERVICE SYSTEMS CHALLENGE TRADITIONAL TRAINING APPROACHES

The report provides the context for a discussion of training practices by reviewing the changing nature of treatment approaches and service delivery systems over the past 15 years. There is increasing concern that training, especially at the preservice level, bears little relation to these changing trends in service delivery, the demands of the actual work, and even less relation to the needs of the children and families served. Many programs have not sufficiently altered their approaches to education and training, continuing to focus on traditional forms of practice in traditional settings. There are few examples of training programs that incorporate the values, aptitudes, and skills reflecting current practice, such as the involvement of parents and consumers, interdisciplinary collaboration, strengths-based assessment and intervention, wraparound services, cultural competence, and the use of natural informal supports and resources.

Conclusions of a 1992 survey of key stakeholders in 12 southern states, and a more recent review by three organizations—the Child, Adolescent, and Family Panel of the Mental Health Managed Care and Workforce Training Project convened by the federal Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Policy and Services Research at the University of Pennsylvania—suggest that the competencies related to best practice are not being adequately incorporated into higher education training and are not reflected in professional practice (Goldman & Irvine, 1997). The challenges are to reform training systems so that the content is relevant to practice, and to assure that what is taught in training is transferred into practice in the workplace.

CORE COMPETENCIES OF PRACTICE IN A SYSTEM OF CARE

Competence involves a person's knowledge, skills, and attitudes. Put most simply, competence is the ability to do the right thing, at the right time, for the right reasons (Knapp et. al., 1993, p. 143). Two

examples of sets of recommended core competencies—both cited by the Child, Adolescent and Family Panel as exemplary for practitioners working with children with emotional and behavioral problems in systems of care settings—are those developed by the Program in Community Mental Health at Trinity College in Vermont, and Pennsylvania's Child and Adolescent Service System Program (CASSP) Training and Technical Assistance Institute affiliated with Pennsylvania State University. In addition, cutting across all specific skills and knowledge, four areas of competence central to working in systems of care are cultural competence, family-professional relationships, systems thinking, and interprofessional education and training.

PROCESSES AND PRACTICES FOR EFFECTIVE EDUCATION AND TRAINING

The report presents what is known about the process of training at both the preservice and inservice levels, and what training practices facilitate learning and are effective in changing practice over time. Principles of adult learning provide a framework for thinking about the most effective way to design learning experiences for adults. Key characteristics of adults that have implications for how they best learn are:

- Adults are autonomous, and wish to be responsible for their own lives and decisions.
- Adults are self-directed and are ready to learn when they judge that they need to know something to help them meet their real life challenges.
- Adults are goal-oriented and will learn in order to accomplish goals.
- Adults are practical and want information that is relevant to making their lives easier or more productive;
- Adults have accumulated life experiences and are interested in learning that builds on these experiences.

Although limited, the data do suggest that the most effective training approaches combine theory, modeling, practice, feedback, and coaching. Programs that incorporate only lecturing and reading for conveying information are less effective. They must be supplemented with more interactive activities such as the following: methods that focus on demonstration and practice; case discussions, role playing, and simulations; and systematic follow-up opportunities after training to support the transfer of training to daily practice through supervision, mentoring, and coaching.

Preservice Training

Examples of programs with innovative approaches to preservice professional training include the Community Mental Health Program at Trinity College in Vermont, the doctoral studies program in child and

family policy at the University of South Florida, the Training for Interprofessional Collaboration Project developed at the University of Washington in Seattle, and the clinical child psychology internship program at the University of New Mexico Health Sciences Center.

Inservice Training

For inservice training to be effective, a full commitment reflected throughout the organization, and a close tie to program goals, objectives, and priorities, is essential. As summarized by the National Staff Development and Training Association (NSDTA), an affiliate of the American Public Human Services Association, the essentials for sound inservice training include the following (NSDTA 1993): administrative support; an organizational climate that permits looking at problems and the means to resolve them; management's commitment to the value of cooperative planning and the development of ways to work together to meet program and staff needs; a realistic understanding by management of what one can expect from a sound staff development and training program; and reinforcement and follow-up of training programs by supervisory and managerial staff. Training commonly fails because of such elements as these: persistence of a classroom mentality; lack of management commitment to training; lack of performance-based evaluation; too much content being covered; inappropriate trainees selected for a particular training; or lack of follow-up after training.

PROMISING APPROACHES TO TRAINING

One example of a comprehensive approach to training at both the preservice and inservice levels is in the state of North Carolina, through its Pitt and Edgecombe-Nash Public Academic Liaison *(PEN-PAL)* Project. This project was funded by the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Child and Family Services Section, through a grant from the Center for Mental Health Services' Comprehensive Community Mental Health Services for Children and Their Families Program. In partnership with East Carolina University, *PEN-PAL* formed the East Carolina University Social Sciences Training Consortium to work with project staff and community stakeholders to develop state-of-the-art curricula, and provide training and consultation to service providers, family members, community representatives, and university graduate students. The Consortium helps prepare students in preservice professional training programs in child- and family-serving fields to work effectively in a collaborative, integrated system of care for children who have emotional/behavioral disabilities and their families. This purpose is achieved through: 1) infusion of system of care principles into existing course work; 2) supervised field placements for students in child-serving agencies who are delivering services through Individual Service Teams; 3) the development of a graduate course in collaborative theory and practice; and 4) national presentations, publications in professional journals, and dissemination of products. They have

also developed the *PEN-PAL* Training and Technical Assistance Resource Center to provide intensive inservice training and technical assistance for and with service providers and families.

Other examples of innovative approaches to training for work in systems of care include work being done in Santa Barbara County in California and in the state of Vermont, a specific training curriculum approach for case managers in Hawaii's 'Ohana Project, and a training for families, neighborhood residents and others in the principles and practice of family support through the People in Partnership Initiative in Houston, Texas.

CONCLUSION

There is a need for all those involved in training to develop a clear understanding of the necessary competencies based on a set of broad principles and knowledge of what works to improve outcomes, and what appear to be promising practices even if not yet entirely supported by empirical findings. There also is a need to develop training systems that incorporate effective training methods and assure that those in practice are competent in using the knowledge, skills, values and attitudes they possess. There is much that can be done by universities and colleges, community agencies, federal and state government administrators and policy makers, family organizations and professional organizations, and accrediting boards to work together to ensure that training leads to improved practice and ultimately results in better outcomes for children and their families.

Chapter I
Introduction

PURPOSE

> *A training program isn't worth the paper it's written on if it doesn't help us to improve our ability to help children and families enhance the quality of their lives (Fecser, 1994, p.1).*

The purpose of this report is to provide information to help federal, state, and local agency administrators, educators, practitioners, consumer families and advocates, professional organizations, accrediting bodies, and managed care organizations develop preservice and inservice education and training that result in a competent workforce that is highly qualified to work in systems of care that improve outcomes for children with mental health problems and their families. This document explores answers to the question: *How can people best be trained to practice in systems of care?* To that end, we seek to identify and describe the following:

- the essential *elements of practice* that are consistent with system-of-care philosophy, provide quality care to children with emotional disturbances and their families, and lead to positive outcomes;
- the *core competencies* to be incorporated into training;
- the essential *processes needed to sustain training* over sufficient time to result in a change in practice; and
- *promising examples* of training curricula and strategies at both the preservice and inservice levels.

PERSPECTIVE

The perspective on training presented throughout this document is based on an ecological and developmental framework that encompasses the principles and values of systems of care. This perspective is reflected in the following three beliefs that are core to the content that follows.

- *The purpose of training is to influence practice. Yet training is only one of many elements that lead to effective practice; therefore, it cannot be viewed in isolation.* Professional competence to provide quality services depends not only on training to attain that competence but also on a policy, fiscal, and organizational environment that supports effective practice.

- *Training is a set of interacting events that affect what a person learns, knows and can do.* Money is wasted on training if it does not have a positive impact on practice. The results of education and training, however, depend on the characteristics of the person being trained, the training itself, the environmental or organizational context in which the person works, and standard-setting or credentialing that confirms that competence has been attained or maintained.

One has to take into account all aspects of the training "system" when developing an approach to training. If people work in situations where they cannot use what they have learned, or professional accrediting bodies do not recognize the necessary competencies that go hand in hand with effective practice, training itself will make little difference.

- *Effective training is a lifelong process.* Training continues even after the completion of a graduate professional program, or after attendance at inservice trainings, conferences, workshops, or continuing education courses. The process of training includes the initial learning of new knowledge and acquisition of skills at the pre-professional level; ongoing supervision, mentoring, and support that allow one to put those knowledge and skills into action; a setting in which staff are seen as partners in determining and designing their own learning needs and those of the organization; and periodic learning of new skills throughout one's life. As noted by Sechrest and Scott (1993), professional training prepares one for a lifetime of learning, laying the foundation of theory and method in a discipline so that the professional can continue to use broad intellectual competencies and strategies of inquiry to test and modify current assumptions, generate new knowledge, and develop new skills.

In the framework that informs this document, the knowledge that underlies best practice does not reside in one place or with one person or group. Everyone is both a teacher and a learner. Faculty who traditionally teach and do research within academic settings, or trainers who teach new skills in an inservice setting, bring their knowledge to those who work in the community. At the same time, they are learning from their interactions with families, service providers, and community participants. What they learn should inform what they teach, research, and write. Their concepts are further refined and tested to help advance theory and practice. There is a synergistic and dynamic feedback process that advances, nurtures, and reinforces the principles of a system of care approach to service delivery. The ultimate knowledge base about best practice ideally grows out of the interactions among families, service providers, theorists, and researchers.

Recognizing that staff who provide services in systems of care represent a variety of disciplines, this document addresses the more general ideas that cut across disciplines, rather than focusing on the specifics of any particular profession or role (e.g., social work; clinical, counseling, school, and community psychology; child psychiatry; medicine; nursing; teaching; mental health counseling; marriage, family, and child counseling; public health; family advocacy). People from each of these disciplines play an important role in serving children and families in a system of care, and many professions are examining the relevance of their own preprofessional programs and proposing changes.

The focus of this document, however, is to articulate a common base of knowledge, skills, values, and attitudes that cuts across all professions and roles, and ideally should be part of the training for all individuals working in a system of care, regardless of the group with which they identify, or the role they occupy. The same holds true whether one is working at the direct service delivery level, the supervisory or administrative level, at the policy-making level, or in advocacy.

ORGANIZATION

Chapter II provides the context for a discussion of training practices by reviewing the changing nature of treatment approaches and service delivery systems over the past 15 years, and the resulting concern that professional training programs have not sufficiently altered their approaches to education and training to reflect these changes. As a consequence, many agencies that comprise child-serving systems have had to fill the gap and train and/or retrain workers through inservice training to ensure a competent workforce.

> *If building systems of care is anything like building houses, there is something we can learn about training from construction. To build a house, you need "resources" like wood, nails, and shingles; "craftsmen" with the specialized skills; and "tools" to assemble the resources into a functional structure that serves a very specific purpose. Most important, the homeowner provides the dream, needs, and basic design. Clearly, it is not enough to be resource-rich — one must have the skills and tools to engage the resources meaningfully and well. That is really what training is all about — providing the skills and tools necessary to use the resources effectively on behalf of children and families* (Mazer, 1996, adapted from Fecser, 1994).

Chapter III addresses the content of effective training by examining the core principles, values, and assumptions that guide practice and need to be reflected in training, and examines the recommended core competencies for working in systems of care. The chapter explores what it means to be competent, and provides examples of core competencies that have been developed and are being used in practice. These examples include competencies specifically developed for the children's mental health field, as well as cross-cutting competencies that include cultural competency, family-professional relationships, systems thinking, and interprofessional practice. Examples from Trinity College in Vermont and Pennsylvania's Child and Adolescent Service System Program (CASSP) Training and Technical Assistance Institute are provided.

Chapter III presents what is known about the process of training at both the preservice and inservice levels, and what training practices facilitate learning and are effective in changing practice over time.

Chapters IV and V present examples of promising practices. Throughout the country, with funding from such sources as the federal Center for Mental Health Service's Comprehensive Community Mental Health Services for Children and Their Families Program, The Annie E. Casey Foundation's Mental Health Initiative for Urban Children, and The Robert Wood Johnson Foundation's Mental Health Services Program for Youth, states and communities are developing innovative approaches to serving children with serious emotional and behavioral problems and their families. Interesting and creative approaches to designing, developing, and delivering training for those working in these systems of care are emerging. Chapter IV describes a comprehensive approach to training at both the preservice and inservice levels in the state of North Carolina, through its *PEN- PAL* Project. Chapter V provides short descriptions of approaches to training, including examples from the state of Vermont and Santa Barbara County, California; a specific training curriculum approach for case managers in Hawai'i's 'Ohana Project; and a training for families, neighborhood residents, and others in the principles and practice of family support through the People in Partnership Initiative in Houston, Texas.

This document concludes with Chapter VI on the challenges and lessons learned from the field and recommendations for actions that can be taken by those who provide training, those who receive training, and policy makers whose actions have a direct effect on training.

METHODOLOGY

In addition to a thorough review of the literature, the information contained in this document was gathered from a number of sources. A work group consisting of state and local children's mental health administrators, family advocates, and university-based faculty, met for two days in April 1998 to help reach a consensus about how people in various disciplines (psychology, social work, psychiatry, special education) can best be trained at both the preservice and inservice levels to practice in systems of care. The group helped develop the concepts that are the framework for this paper. They also helped identify sites that were examples of promising practices. Suggestions for promising practices were also provided through a survey conducted by the Division of Children, Youth, and Families of the National Association of State Mental Health Program Directors, and a survey of the Comprehensive Community Mental Health Services for Children and Their Families Program sites. Because of the extensive innovative work on training in North Carolina, Martha Kaufman was invited to write a chapter about the *PEN- PAL* Project for this monograph. Information from other sites was gathered through telephone interviews and review of their written materials.

An effort organized by the American Psychological Association's (APA) Committee for Children, Youth and Families, and APA's Division of Children, Youth and Family Services, also served as a precursor to this document. An interdisciplinary work group on Innovative Training Approaches for Psychologists Working in the Public Sector, chaired by Judith Meyers and Jane Knitzer, was organized specifically to promote more effective training of psychologists to work with the population of children and families of concern to the public sector. This group developed a set of principles and a framework for action, and is in the process of identifying innovative doctoral, internship, and continuing education training approaches, and developing a resource guide for faculty, internship directors, and students. Many members of that effort participated in the work group that helped with the preparation of this document.

Chapter II
Changes in Treatment and Service Systems that Challenge Traditional Training Approaches

One of the major challenges for the children's mental health field is to develop and maintain a well-trained workforce of personnel who can staff systems of care for children with, or at risk for, serious emotional and behavioral problems and their families. Although both treatment practices and service systems are rapidly changing, our nation's education and training programs are not keeping up with these changes. They are not effectively preparing people to assure that their knowledge, skills, and attitudes reflect the values, principles, and most promising practices that are the foundations of these systems.

ADVANCES IN SERVICE DELIVERY AND PRACTICE

The pace of change in the conceptualization, organization, financing, and delivery of services to support systems of care for children and their families at the state or local level has been dramatic, beginning with the Child and Adolescent Service System Program (CASSP) in 1984 to the Comprehensive Community Mental Health Services for Children and Their Families Program first funded in 1993. Managed care, the State Child Health Insurance Program, and welfare reform are the most recent policy changes affecting service delivery, following more than a decade of reform growing out of the system of care and family advocacy movements. As a result of these reforms, as well as the expanding knowledge base from both research and evaluation of demonstration programs, answers to questions such as *where, what, with whom, by whom, and how* services are provided to children with, or at risk for, serious emotional and behavioral problems and their families have changed dramatically over the last 15 years. For example:

- The service array has broadened beyond acute psychiatric hospitalization, long-term residential placement, and traditional office-based, individual therapy to include crisis services of all kinds, in-home services such as family preservation and family support, school-based services, intensive case management, respite, mentoring, and therapeutic group and foster family care.
- Treatment has veered away from long-term approaches based on psychoanalytic and psychodynamic theories to briefer interventions based on ecological theories and models. Family systems therapy and cognitive behavioral therapy are two examples.
- Greater recognition is given to the importance of culture in meeting the needs of children and families and in designing and implementing services that are culturally competent.

- There is increasing emphasis on understanding the different systems involved with children and families beyond mental health, such as child welfare, education, health, and substance abuse, and in creating a more integrated service delivery system.

- The wraparound model promotes the flexibility to provide whatever a child or family needs to help the child stay in the home, school, and community.

- Families play an *integral* role in the treatment and support of their children and are more often viewed as full partners in the design, development, delivery and evaluation of systems of care.

- There is a growing recognition of the need for individualized programs for special populations, such as children in foster care and in adoptive families, adolescents who are sexual offenders, children who are sexually abused, children and families who are homeless, children exposed to harmful substances in utero or as infants, and children exposed to violence.

- Services are more frequently organized and financed using managed care principles and practices with greater emphasis on accountability for outcomes.

- Professionals such as psychiatrists, psychologists, social workers, nurses, and educators perform a variety of roles that may differ from those for which they have been originally trained. Rather than spending the major portion of their time as providers of direct services, they may assume such roles as advocates, consultants in assessment and treatment planning, administrators, evaluators, and trainers.

- Front-line case management and service delivery may be provided by those who do not have formal professional training. For instance, a survey of the children's mental health workforce in South Carolina revealed that 45 percent of personnel were trained at the bachelor's level (Hanley, 1994). Agencies are increasingly hiring family members and neighborhood residents in "paraprofessional" roles, based on their life experiences rather than years of education or completion of formal preservice training.

HOW CAN HIGHER EDUCATION KEEP PACE WITH THE CHANGES ?

A wide range of professionals including psychologists, social workers, child psychiatrists, psychiatric nurses, special educators, marriage and family therapists, and mental health counselors are involved in planning, administering, and delivering services within systems of care. Most of these professionals have been trained in graduate and postgraduate programs within their separate disciplines. There is increasing concern that preservice academic training bears little relation to the demands of the actual work, the changing trends in service delivery, and even less relation to the needs of the children and families served. Most professional training programs remain categorical, with curricula limited by the requirements of their professional associations. There are few examples of training programs that incorporate the values, aptitudes, and skills reflective of current practice, such as the involvement of parents and consumers, interdisciplinary collaboration, strengths-based assessment and intervention, wraparound services, cultural competence, and the use of natural informal supports and resources.

In 1992, key stakeholders in 12 southern states—including parents of children with serious emotional disturbance, state mental health agency officials, local service providers, and advocates—were surveyed about workforce issues related to the delivery of community-based services for children and adolescents and their families. Conclusions drawn from that survey are still true 6 years later: "Too often, the academic preparation of those entering child-serving systems has failed to give them the knowledge, skills, or attitudes needed to implement effective community-based systems of care" (Pires, 1996, p. 282). Pires found that:

- The types of services that comprise a system of care involve new, still evolving technologies for which many staff have not been trained.
- The interagency collaboration and service integration called for in most systems of care involve staff from multiple systems with different mandates, financing streams, training, and orientation, with no training in how to work together.
- Meaningful involvement of families often requires staff to acquire new skills and to change existing attitudes.
- Few are trained in cultural competencies, not just sensitivities, yet the population served is increasingly ethnically and culturally diverse.
- Staff must be familiar with a broad developmental range from infancy through the transition to adulthood, and a broad range of disorders.

While the public service delivery system has concentrated on developing a range of services to enable it to better serve those youngsters for whom traditional mental health settings and services are ineffective and/or inappropriate, academic training programs have not only continued but perhaps even increased their focus on traditional forms of therapy in traditional mental health settings (Friedman, 1993, p. 303).

Respondents to this survey reported a lack of adequate preparation and training as a problem across all disciplines. More than 70 percent believed that the major reason staff are not adequately prepared is because university curricula are not relevant. As Friedman (1993) concludes, "While the public service delivery system has concentrated on developing a range of services to enable it to better serve those youngsters for whom traditional mental health settings and services are ineffective and/or inappropriate, academic training programs have not only continued but perhaps even increased their focus on traditional forms of therapy in traditional mental health settings" (p. 303).

The Child, Adolescent, and Family Panel of the Mental Health Managed Care and Workforce Training Project convened by the federal Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Policy and Services Research at the University of Pennsylvania, recently reviewed materials related to provider

competencies and found similar results (Goldman & Irvine, 1997). Panel members emphasized that the competencies related to best practice are not being adequately incorporated in higher education training and too often are not reflected in professional practice.

THE LINK BETWEEN TRAINING, PRACTICE, AND IMPROVED OUTCOMES

No matter how innovative system reform efforts are, their effectiveness in improving outcomes for children and families is ultimately limited by the quality and competency of the managers and direct service delivery personnel who provide services on a daily basis. Results of recent evaluations are indicating that the effectiveness of systems of care in improving outcomes for children and families may be dependent not only on policy, administrative structures, the array of services provided, and financing, but also on what happens in practice (Bickman, Summerfelt, & Foster, 1996; Pires, 1996). A change in philosophy, value base, and the way services are organized and delivered may not be sufficient to help children and families improve their functioning at home, school, and in the community, until the workers within the system actually change their practice to help families achieve their clinical goals, overcome barriers to change, and mobilize their available resources. Change at the system, organizational, and individual practice levels may be necessary before we will see improvement in outcomes for children and families. As noted by Robertson (1997), critical factors related to the ability to change practice are the attitudes, behavior, and skills of direct care, supervisory, and administrative staff members. He views staff development and the implementation of new programs and services to children as going hand in hand.

No matter how innovative system reform efforts are, their effectiveness in improving outcomes for children and families is ultimately limited by the quality and competency of the managers and direct service delivery personnel who provide services on a daily basis.

Training at both the preservice and inservice levels, when done well, becomes the *essential* link that translates reforms into a different way of practice. Training is the best intervention for promoting the most effective interactions between staff and the children and families they serve. How does this translate to the specific competencies to be taught and the ways in which they are taught to ensure effective practice? Chapters III and IV explore answers to this question.

Chapter III
The Essential Elements and Core Competencies of Practice in a System of Care

THE ESSENTIAL ELEMENTS OF PRACTICE

The core principles, values, and assumptions that guide practice in children's mental health systems of care, as well as other similar community-based, family-centered service systems for children, have been articulated by many who represent programs developed within different professional disciplines including mental health, child welfare, family support, health, special education, and juvenile justice. A review of these principles reveals enough commonality to suggest that, at this point in time, there is broad consensus about the essential elements forming the foundation for practice (Hooper-Briar & Lawson, 1994; Kinney et al., 1994; Stroul & Friedman, 1994; Schoenberg, 1995; American Academy of Child and Adolescent Psychiatry, 1996; Zlotnik, 1997a).

These principles include the following:

- ***Community or neighborhood-based***. Whenever possible, services and resources are provided as close to a child's home and community as possible so that there is the least disruption of the child's daily living and the greatest opportunity for participation by the key figures in the child and family's life.

- ***Culturally responsive***. The values and customs of families from different cultures are acknowledged and valued, and service delivery, training, policy development, and evaluation are designed to be culturally competent. This involves recognizing cultural differences, understanding how families and systems are shaped by their cultures, attending to the dynamics of differences, and making adaptations to better serve culturally diverse families.

- ***Families as partners***. Families and professionals work together in relationships of respect and mutual support in all aspects of planning, program development, service delivery, and evaluation. Families have the lead voice as well as choice in decisions regarding treatment plans for their children.

- ***Holistic***. An effective system is based on a broad, ecological framework whereby a child is viewed in the context of his or her family, community, and culture. In assessing and seeking solutions, workers consider the whole child, including the emotional, physical, cognitive, social, spiritual, and environmental dimensions and their interactions.

- ***Individualized***. In effective systems, treatment plans are tailored to meet the needs and goals of the individuals being served, with flexibility to implement individualized services responsive to the gender, culture, and other unique conditions of a child and family.

- ***Integrated***. In effective systems, staff work together across disciplines and system agency boundaries to provide integrated, effective, and efficient care.

- ***Strengths-based***. Effective systems emphasize the strengths, capabilities, resources, and needs of the child, family, culture, and community rather than the deficits, and address the challenges and problems they face. These strengths and resources are included in an individualized assessment, and in the development and implementation of service plans. Behaviors traditionally labeled as pathologies are reframed as potential assets. For example, a child previously labeled hyperactive may be described as high energy or fast-moving. An adolescent who has run away and fended adequately may be viewed as a youth who has good survival skills. Interventions help families recognize their own potential to help themselves.

Given these principles, what are the competencies that an individual needs to promote these principles in practice?

CORE COMPETENCIES

What Does It Mean to Be Competent?

We generally think of competencies as a set of knowledge, skills, values, and attitudes that are needed to perform a task or provide a service. Competencies are reflected in what people think (knowledge), do (skills), and feel (attitudes). "Competent" workers have the knowledge and skills they need to perform their jobs. Knowledge and skills are acquired through formal training, independent study, supervision, work experience, and personal life experience. Competent ability, however, has little meaning if it does not translate into competent practice. Ongoing monitoring and supervision in the workplace, therefore, are important in assuring the link between ability and practice.

A formal definition of competence is "the capacity to analyze a situation, consider alternative approaches, select and skillfully apply the best observation or intervention techniques, evaluate the outcome, and articulate the rationale for each step of the process" (Smith & Hutchison, 1992, p. 3). Put more simply, "Competence is the ability to do the right thing, at the right time, for the right reasons" (Smith & Hutchison, 1992, p. 3; Knapp et al., 1993, p. 143)." Competence involves not only knowing what to do, how, and when, but also knowing what *not* to do or when *not* to do it (Sechrest & Scott, 1993).

Although it is important to increase competency in the workforce, it is helpful to keep in mind that not all competencies can be acquired through training. Certain attitudes, orientations, and personal characteristics that are cited as critical for people working with children and families, particularly in a setting that is part of a community-based system of care, may not necessarily be acquired through specific training. For instance, Henggeler and his team, who have developed Multisystemic Therapy (MST), write that they

select their master's-level MST therapists on the basis of their motivation, flexibility, common sense, and street smarts, "the master's degree being viewed more as a sign of motivation than as evidence of a particular type or level of clinical expertise" (Henggeler et al., 1998, pp. 20-21). Sechrest and Scott (1993) list personal qualities of intelligence, problem-solving ability, flexibility, tolerance, and compassion as those competencies most often named as important for clinical psychologists who work with people who are seriously mentally ill.

EXAMPLES OF CORE COMPETENCIES

To develop an effective approach to training and professional development for staff who work in systems of care, it is necessary to translate the functions of this work into a specific set of skills, knowledge, and characteristics. This is no easy task. The Child, Adolescent, and Family Panel of the Mental Health Managed Care and Workforce Training Project identified and reviewed a range of materials about core competencies and training curricula for children's mental health providers, including those developed by federal or state agencies, consumer groups, and professional organizations. The Panel cited two examples as exemplary in articulating a comprehensive set of core competencies for practitioners working with children with emotional and behavioral problems: one from the Trinity College of Vermont's Center for Community Change, and the other developed by the Pennsylvania Child and Adolescent Service System Program Training and Technical Assistance Institute.

Trinity College of Vermont

Trinity College's set of core competencies was developed based on the thinking, writing, and practical experience of leading individuals in the field and refined through a national multi-perspective review process. The competencies are multi-disciplinary and multi-cultural and focus on respect for consumers/clients and their families, on teaching a knowledge base rooted in the life experiences of these groups, on the value of multi-disciplinary learning and service delivery, and on systems theory. Exhibit 1 lists the major areas of competencies included. The Child, Adolescent, and Family Panel described the Trinity College competencies as "comprehensive in outlining the full range of competencies needed to operate successfully within a system of care for children and adolescents with serious emotional disturbance and their families" (Goldman & Irvine, 1997, p. 55).

The Trinity College competencies are "comprehensive in outlining the full range of competencies needed to operate successfully within a system of care for children and adolescents with serious emotional disturbance and their families (Goldman & Irvine, 1997, p. 55)."

EXHIBIT 1
TRINITY COLLEGE
COMPETENCIES FOR STAFF WHO WORK WITH CHILDREN AND ADOLESCENTS EXPERIENCING A SERIOUS EMOTIONAL DISTURBANCE AND THEIR FAMILIES

I. Demonstrates respect for children and adolescents experiencing a serious emotional disturbance and their families.

A. Uses language and behavior which consistently respects the dignity of children and adolescents experiencing a serious emotional disturbance.

B. Demonstrates holistic understanding of children and adolescents experiencing a serious emotional disturbance and their families.

C. Involves child or adolescent in all aspects of service planning and support activities.

D. Provides information as needed.

E. Communicates understanding of unique issues facing family members.

F. Solicits family input and collaboration in service planning and support activities.

G. Demonstrates knowledge of family support resources.

H. Provides formal and informal support as needed.

II. Demonstrates knowledge about serious emotional disturbance.

A. Demonstrates knowledge about the differential characteristics and courses of serious emotional disturbances/disability.

B. Demonstrates knowledge about psychotropic medications.

C. Demonstrates understanding of the effects of stressful life events on children, adolescents, and families.

III. Demonstrates understanding of principles of collaborative community-based care.

A. Understands and demonstrates the principles of unconditional care.

B. Understands the principles of child and family-centered services.

C. Understands the principles of community-based care.

Exhibit 1 (Continued)

IV. Demonstrates knowledge of a variety of approaches to intervention and support for children, adolescents, and their families.

A. Demonstrates respectful communication and/or counseling skills.
B. Demonstrates ability to teach simple and complex skills including physical, social, intellectual, and emotional skills
C. Demonstrates understanding of a variety of program models and philosophies (and acknowledges that these change as knowledge evolves over time).
D. Demonstrates knowledge of a range of crisis prevention and intervention approaches.

V. Demonstrates ability to design, deliver, and ensure highly individualized services and supports.

A. Routinely solicits personal goals and preferences.
B. Designs personal growth/service plans which "fit" the needs and preferences of the child/adolescent and family.
C. Encourages and facilitates personal growth and development toward maturation and wellness.
D. Facilitates and supports natural support networks.

VI. Works in cooperative and collaborative manner as a team member (agency teams, family members, service recipients, foster parents, concerned others).

A. Coordinates service and support activities with others.
B. Assists in building positive team relationships.

VII. Demonstrates knowledge of a variety of service systems for children and adolescents experiencing serious emotional disturbance and their families.

A. Identifies and accesses wide range of community resources.
B. Develops and maintains good relationships with community representatives.
C. Demonstrates knowledge of entitlement and benefit programs.
D. Integrates community resources into service planning.
E. Participates in pubic education and overall advocacy.

Exhibit 1 (Continued)

VIII. Demonstrates knowledge of legal system and individual civil rights.

A. Demonstrates knowledge of legal system.
B. Demonstrates knowledge of individual rights.
C. Connects individuals to legal and advocacy resources as needed and/or requested.

IX. Conducts all activities in a professional manner.

A. Adheres to recognized ethical standards.
B. Performs work in a positive manner.

X. Pursues professional growth and development.

A. Seeks out learning opportunities.
B. Evaluates work effectiveness.
C. Integrates new learning into daily work practices.

The Trinity College competencies are the basis for the College's Master's and Certificate Programs in Community Mental Health (see pp. 29-30 for program description). They also have been adapted for use in the Santa Barbara County, California Multiagency Integrated System of Care (MISC) and the North Carolina *PEN-PAL* Project, both sites funded through the Center for Mental Health Services' Comprehensive Community Mental Health Services for Children and Their Families Program. Santa Barbara uses the competencies as a basis for training their direct service staff. (See Appendix B for a more detailed presentation of the Trinity competencies as adapted in Santa Barbara.) North Carolina includes the competencies in their Handbook for Individual Service Team Coordinators to be used as a checklist for personal training needs and to help staff identify strengths and training needs.

The Pennsylvania Child and Adolescent Service System Program (CASSP) Training and Technical Assistance Institute

The Pennsylvania CASSP Training and Technical Assistance Institute, affiliated with Pennsylvania State University, coordinates, sponsors, and facilitates opportunities for information-sharing, training, and technical assistance and consultation in children's mental health issues across the state of Pennsylvania. The Institute has developed a set of core competencies as a guideline for professionals to become certified as children's community mental health workers, providing a tangible standard for practitioners reflecting

CASSP principles and knowledge about best practice. The majority of these workers are individuals with master's or bachelor's degrees in counseling, psychology, and social work, often trained in adult mental health (Hansen, 1996).

The competencies presume that services are delivered in a child-centered, family-focused, community-based, multi-system, culturally competent, and least restrictive/least intrusive environment. The core competencies are divided into three major categories: children, family, and community. The knowledge and skills related to individual children are organized into seven developmental age groupings from birth through age 20. For each age group, there are specific competencies related to social, cognitive, emotional, and physical development; the cultural context; impairment and risk of impairment; assessment; interventions; and professional, legal, and ethical issues.

The family portion outlines competencies for working effectively with families as partners, and the community portion outlines requirements for working effectively with the breadth of other service systems and community resources (i.e., mental health, mental retardation, education, child welfare, juvenile justice, drug and alcohol abuse, early childhood prevention and intervention, social welfare, vocational rehabilitation, health care, legal, religious communities, civic and youth organizations, parent groups, self-help and support groups, and formal and informal culture-specific groups). (See Appendix C for the Institute's set of core competencies.)

In addition to these two examples, individuals or groups within professional disciplines involved in systems of care have developed or recommended their own set of core competencies, specific to their profession (Magrab & Wohlford, 1990; American Mental Health Counselors Association, 1993; American Academy of Child and Adolescent Psychiatry, 1996; National Association of School Psychologists, 1997). The Center for Mental Health Services (CMHS) developed a set of curriculum modules for educating social workers in child mental health, incorporating many of the principles and practices outlined above (Johnson, 1993). A similar effort for psychologists, also sponsored through CMHS, produced a model for specialty training in psychological services for children, adolescents, and their families that is competency-based and integrates the principles and practice of a systems of care approach in assessment, intervention, research, and evaluation (Roberts et al., 1998). Recently, a number of social work education programs have partnered with public agencies to develop family-centered competencies that are to be acquired by students as well as by agency staff who are participating in training programs. Offering empowerment-oriented, family-centered, strengths-based practice from an ecological perspective are common goals articulated by some of these contemporary social work education programs (Zlotnik, 1997b).

CROSS-CUTTING COMPETENCIES

Four areas of competence that are increasingly recognized as fundamental to working in systems of care, and cut across all specific skills and knowledge, are often overlooked in preservice training programs. These areas are cultural competence, family-professional relationships, systems thinking, and interprofessional education and training. Because of their importance, we highlight them here.

Cultural Competence

Staff working within the context of systems of care are expected to provide services within appropriate cultural, racial, and ethnic contexts for the children and their families with whom they work (Cross et al., 1989; Isaacs and Benjamin, 1991). Professionals responsible for training are increasingly attending to how to help others develop the skills that will enable them to practice in a manner that is responsive to cultural differences. At the preservice level, Roberts et al. (1998) outline what a graduate-level curriculum for psychologists ought to address to "facilitate its trainees' development from awareness and appreciation of their own culturally based beliefs and attitudes to demonstration of skills to implement culturally responsive services" (p. 297). These include:

- the role of ethnicity, race, and culture (broadly defined), along with related beliefs and value systems, in child development and mental health;
- the development of ethnic, racial, and cultural identity;
- cultural norms in the determination of psychopathology;
- how the diversity of beliefs, values, and expectations, as well as a difference in social status of a child and family and a professional, can influence interactions between them;
- the match between the child's and family's view of the problem and the provider's treatment theory and methods; and
- treatment and assessment of multicultural populations.

The authors advise that multicultural issues and a sociocultural perspective be integrated in all course work, research experiences, and practica, rather than taught in discrete seminars and experiences.

At the inservice level, many individual states have developed their own approaches to training their child mental health staff in culturally competent practice. One national approach is sponsored by the National Technical Assistance Center for Children's Mental Health at Georgetown University's Child Development Center. The Center offers a three-day Train the Trainers Institute on Cultural Competence on a biennial basis. The objectives of the training are to:

- improve and enhance cultural competence capacity, training, and outcome accountability in human service delivery systems;
- provide information and knowledge to assist policy makers, administrators, practitioners, consumers, and advocates in becoming change agents at multiple levels and in multiple roles to support culturally competent practices;
- identify strategies for developing and implementing culturally competent approaches that are responsive to the culturally defined needs of children, families, and communities; and
- develop and improve cross cultural skills that can be applied in working effectively with culturally diverse children, families, and communities.

The training includes a range of modalities: didactic, laboratory activities, facilitated peer group meetings, and cultural exercises. The Institute offers 16 courses ranging from beginning level to advanced. (See Appendix D for a description of the courses offered.)

Family-Professional Relationships

A central value and practice in community-based systems of care is a family-centered approach to service delivery. No longer are professionals viewed as the sole experts and leaders, and family members as the cause of the problems and the recipients of services. Instead, families are valued for their expertise and are involved as key decision makers in the treatment planning, delivery, and evaluation of services for their children.

As summarized in a recently published document on family-professional relationships (National Peer Technical Assistance Network, 1998), for professionals to relate to families in a mutual and interdependent way, they need an array of skills and abilities that include the following:

- ability and commitment to identify strengths in people and groups;
- genuine respect for diverse perspectives and lifestyles;
- the ability to promote inclusion of a wide variety of stakeholders;
- a capacity to listen and reflect;
- the capability of considering a range of issues that are made more complex because of the addition of multiple viewpoints and opinions;
- intuition and ability to synthesize;
- an ability to subordinate one's own ego (to put oneself aside in the interest of the group);

- skill and creativity in helping people become more aware and confident of their own abilities;
- appreciation of when to step back and the ability to help the individual or group assume decision-making and action;
- ability to analyze power relations and help others to do so;
- knowledge about how to gain access to information;
- ability to reflect on and criticize ongoing processes, including one's own role in those processes; and
- the flexibility to work with a broad array of service options and possibilities.

An in-depth exploration of the issues of family-professional collaboration is presented in Volume II of this series, *Promising Practices in Family-Provider Collaboration* (see Simpson et. al., in press).

Systems Thinking

Systems thinking—how and why all the separate components of a system fit together—underlies the values and principles of a system of care approach. Therefore, acquiring the knowledge about systems theory and the ability to apply it in practice is necessary to anyone working within a system of care. Systems thinking enables workers to appreciate the connectedness of people, groups, organizations, agencies, institutions, and neighborhoods that comprise the community in which they work—all separate entities but also parts of related networks, such that intervention in one part of the system has repercussions for the whole system. In this framework, "the success of the whole community depends on the success of its individual members, while the success of each member depends on the success of the community as a whole" (Capra, 1996, p. 298).

The basic principles for building sustainable systems of care for children, their families, and communities include interdependence, the cyclical flow of resources, partnership, flexibility, diversity, and, as a consequence of all those, sustainability. Understanding these principles helps individual workers understand and operate with a vision that touches on the connectedness of all aspects of community life relevant to improving outcomes for children and families. These principles are described in more detail in the National Peer Technical Assistance Network's document on Family-Professional Relationships (1998), drawing from the works of Capra (1996), Senge (1994), and Schorr (1997).

Interprofessional Education and Training

Closely linked to a systems approach to thinking and practice is the growing movement toward interprofessional education and training, based on the belief that care for children with, or at risk for, serious emotional problems and their families is best delivered within an interdisciplinary model in which the perspectives of various professionals are integrated (Roberts & Magrab, 1991; Friedman, 1993; Zlotnik, 1997b). Interprofessional practice is not a new discipline but a different way for existing disciplines to interact (Short, 1997). Although strong identity and competence within each profession or discipline is still seen as critical, interprofessional training assumes that there is a set of skills beyond those taught in specific disciplines that are necessary for professionals to practice effectively together.

Interprofessional education is defined by the Commission on Interprofessional Education and Practice as preparing people for "the communication, cooperation, and coordination that occurs between members of two or more professions when they are dealing with client concerns that extend beyond the usual area of expertise of any one profession" (Gardner et al., 1997, p. 1). That collaborative relationship is further described as "an interactive process through which individuals and organizations with diverse expertise, experience, and resources join forces to plan, generate, and execute solutions to mutually identified problems related to the welfare of families and children" (Knapp et. al., 1993, p. 140).

Based on a literature review and focused consultations with direct service practitioners, mid-level program managers, and policy makers in education, social service, and health professions, Smith and Hutchison (1992) developed a list of the most frequently cited competencies. Brandon and Meuter (1995) also described a set of competencies for interprofessional practice. Together, the competencies cited include the personality traits, knowledge, abilities, and values listed in Exhibit 2.

This chapter has discussed the content and core competencies of training for effective practice in systems of care. A review of the literature has shown that there is an emerging consensus about the common elements of core competencies across fields, both within disciplines and across disciplines through an integrated approach to education and training. Some of these elements can be acquired or enhanced through training. Others are personal qualities inherent within an individual that may not necessarily be responsive to training, necessitating care in looking for these characteristics in the recruiting and hiring process. In the next chapter we examine what is known about the process of education and training at the preservice and inservice levels. What training practices facilitate learning, result in transfer of learning to the work site, and are effective in sustaining the results over sufficient time to lead to a change in outcomes for those being served?

EXHIBIT 2
COMPETENCIES FOR INTERPROFESSIONAL PRACTICE

Personality Traits:

- Ability to trust, respect, show tolerance for other professionals and practitioners
- Flexibility and openness to suggestions
- Creativity, inquisitiveness
- Patience
- Ability to take risks
- Warmth, empathy

Knowledge and Abilities

- Group process skills - small group/large group dynamics
- Knowledgeable about own profession
- Communication skills
- Ability to communicate with representatives of other professions
- Knowledge of strategies for collaboration - ability to facilitate groups and teams; ability to work in problem-solving mode
- Understanding of collaborative case management and interagency program planning
- Knowledge of how to work in teams and understand the perspective and expertise of team members

World View

- Value of others' knowledge and profession - knowledge of their languages, abbreviations, required protocols
- Recognition that the complexity of problem requires collaboration
- Goals and philosophy in common with practitioners from other professions
- Value of diversity of cultural background, professions, and communication style
- Understanding of the context of a site from different perspectives: e.g., school, clinic, court, family

Chapter IV
Processes and Practices for Effective Education and Training

To understand what is known about the process and practice of effective education and training, we turn to the literature on training as well as to examples of innovative training programs, for guidance in exploring how people learn in training programs, and the factors that influence whether they use what they learn in the workplace—referred to as *transfer of training*.

DEFINITION OF TERMS

Although the terms "education" and "training" are often used interchangeably, they convey different meanings. Education is concerned with broader and longer term thinking, and the creation, synthesis, and application of knowledge. Education provides a conceptual base for the framing of information, developing thinking and problem-solving skills that are transferable to a variety of settings over time (Vander Ven, 1986; Reich, 1998).

Training usually refers to specific information and skill development to meet an immediate practice need. Training, as defined by Goldstein (1993), is "the systematic acquisition of skills, rules, concepts, or attitudes that result in improved performance in another environment" (p. 3). A successful training experience ought to enhance learning and result in the acquisition, retention, maintenance, and generalization of the skills for which one was trained to the work environment (Smith, Ford, & Kozlowski, 1997).

There are also distinctions between education and training at the preservice and at the inservice level. Preservice training refers to the *initial* intensive skills-oriented process that prepares people to acquire the knowledge and skills that define a profession and to assume job responsibilities. The term "professional" implies completion of a course of study of an established knowledge base that draws on well-developed theory, certification or licensing to participate in that professional enterprise, a code of ethics that sets the standards for professional behavior, a set of values, norms, and language, and the ability to practice autonomously (Vender Ven, 1986; Cornell Empowerment Group, 1989). Most staff who work in community settings come from the professions of psychology, social work, psychiatry, special education, nursing, mental health, or marriage and family counseling, and many have completed a master's or doctoral level program, that usually combines classroom instruction and field work.

Inservice training is the process by which staff working in the field are provided experiences designed to improve or change their practices (Sexton et al., 1996), or that enable them to develop and function to the optimum of their abilities in order to achieve program goals, objectives and priorities (National Staff Development &Training Association (NSDTA), 1993). There is an array of diverse education and training opportunities for workers in systems of care for children's mental health (Vander Ven, 1993). These are described in Exhibit 3.

EXHIBIT 3
EDUCATION AND TRAINING OPPORTUNITIES FOR WORKERS IN SYSTEMS OF CARE

Types of Training Programs	Characteristics
University-based, Academic Programs	Preservice doctoral, master's, or specialty degrees
College – Undergraduate	Four-year degree
Learning Center Model	Courses, undergraduate/graduate workshops, consulting, resources
Certificate Programs	Specialized academic programs
Agency-sponsored Training	Formal programs, possible career ladder credit
Agency-based Training and Supervision	Informal training, orientation, in agency inservice training
Specialized Workshops	Sponsored by independent training centers and consultant companies
State Training and Technical Assistance Institutes and Programs	Sponsored with state funding for training on state and local identified needs
Training Conferences	Sponsored by Associations
Learning resources	Journals, newsletters, videos, etc.
Informal Contacts	Informal discussion of work-related issues among pratitioners on and off the job
Technology-Based Approaches	University-based distance learning; use of Internet

Approaches to Training Based on Adult Learning Principles and Strategies

Principles of adult learning are important to consider in designing effective education and training approaches. Research and practice in the fields of staff development and adult learning provide a framework for thinking about the most effective way to design learning experiences for adults (Knowles, 1984; Cantor, 1992; Cranton, 1992; Walizer & Tanner Leff, 1993; Lane & Cassidy, 1994; National Staff Development and Training Association, 1997; Cognitive Design Association, 1998a, 1998b).

Key characteristics of adults that have implications for how they best learn are:

- Adults are autonomous, and wish to be responsible for their own lives and decisions.
- Adults are self-directed and are ready to learn when they judge that they need to know something to help them meet the challenges of their real-life situations.
- Adults are goal oriented and will learn in order to accomplish goals.
- Adults are practical and will want information that is relevant and will make their lives easier or more productive.
- Adults have accumulated life experiences and are interested in learning that builds on these experiences.

A description from The Friend of the Family Capacity-Building Education Program in Houston, Texas, described in more detail in Chapter V, outlines how they have applied the principles of adult learning (see Exhibit 4).

METHODS OF TRAINING

There are various ways that training can be offered, regardless of content. These methods can be classified as information-based, demonstration-based, or practice-based (Salas & Cannon-Bowers 1997).

- **Information-based**—the delivery of concepts, facts, knowledge, or theories through use of lectures, video or slide presentations, or computer-based instruction. These approaches are easy to implement, cost-effective, and practical for training large numbers of people. For this reason they are the most widely used methods in training.
- **Demonstration-based**—the learning objectives rely on methods in which the trainee can observe the required behaviors, actions, or strategies. The trainee is an observer of a situation, scenario, or exercise. This method is effective for presentation of a complex, dynamic, and multifaceted performance.

EXHIBIT 4
THE FRIEND OF THE FAMILY CAPACITY-BUILDING EDUCATION PROGRAM HOUSTON, TEXAS

- The learning activities will be meaningful to the life situations and experiences of the participants, and the results learned can be immediately applied.
- The learners are also leaders.
- Presentations allow opportunity for the training content to be related to personal experience, with the facilitator (trainer) feeling comfortable with analytical scrutiny of their ideas by the participants.
- The teaching approach lends itself to participation, interaction, and involvement.
- There is respect for the diversity of the adult participants, with their unique psychological, social, physical, and professional levels of development.

- **Practice-based**—hands-on practice and feedback on progress. Practice alone does not equal training. It is a necessary but not sufficient condition for learning. "To be effective, practice needs to be guided by cueing, feedback, coaching, or any other mechanism that helps the trainees to understand, organize, and assimilate the learning objectives" (Salas and Cannon-Bowers, 1997, p. 267). Examples of practice-based methods include role-playing, behavior modeling, computer-based simulations, and guided practice through supervision.

There are few empirical studies that have examined relationships between specific training strategies and actual practice changes in those experiencing inservice education. In an article on inservice training for early education, Sexton et al. (1996) summarized the conventional wisdom about what should constitute effective inservice education, drawing from the data gained from a few studies, literature reviews, and meta-analyses conducted with teachers, as follows:

- The most effective training approaches combined theory, modeling, practice, feedback, and coaching. Programs that incorporate only lecturing and reading as a means of conveying information are less effective.

- The four most effective instructional methods: (1) were observation of actual classroom practices, (2) microteaching (practice teaching a short lesson to a small group, and then view a videotape of your teaching), (3) video/audio feedback, and (4) practice. A combination of strategies was necessary to maximize positive inservice training outcomes.

- Peer observation training activities following an inservice training workshop were more powerful than a workshop-only approach or a workshop with coaching procedures.

These same authors surveyed a sample of early childhood intervention systems professionals in Louisiana about inservice training strategies they had experienced, asking their perceptions about the link between training methods and actual practice changes. Not surprisingly, the training strategies most often experienced were passive methods—handouts, lecture, demonstration/modeling by the trainer, small group discussions, and videos or movies.

The strategies that were perceived as having the *greatest impact* on changing practice were:

- observing actual practice
- follow-up job assistance
- demonstration/modeling by trainer
- microteaching
- small group discussion

Those perceived as *least effective* were:

- filling out survey
- being given a list of resources provided by trainer
- being given assignments to do back home
- writing a back-home plan—what you will do as a result of the training
- a follow-up letter reminder
- panel discussions

These service providers perceived inservice training strategies that emphasized practical skills embedded within opportunities to observe and practice specific behaviors as being the most likely to change practice. More passive and general training strategies were rated as resulting in very little or no change in practice.

There appears to be consensus that passive learning through lectures and handouts must be supplemented with more interactive activities such as case discussions, role playing, and simulations, methods that focus on demonstration and practice, and systematic follow-up opportunities after training to actively support the transfer of training to daily practice through supervision, mentoring, and coaching. Of interest, however, is that surveys of professionals about their preferences for types of inservice training find that their preferences are not entirely consistent with best practices in training. Models that are more intensive in design and include active participation and follow-up seem unrealistic to practitioners (Gallagher et al., 1997). People responsible for training may need to consider strategies for moving participants from preferred formats to those that are most effective, balancing participants' needs and concerns with the implementation of preferred practices.

PRESERVICE TRAINING

Preservice training has been described as a sequence of learning that moves a student from a relative lack of knowledge to increasing degrees of competence, through three stages (Roberts et al., 1998):

- *Exposure*—introduction to a topical area in a didactic seminar or through observation in an applied setting;
- *Experience*—the practice of the topical area or activity; and
- *Expertise*—course work and extensive experience in the topical area at a level of competence at which the professional can practice independently.

A comprehensive training program assists trainees to achieve *exposure* in all relevant areas, to have *experience* in many areas, and to acquire *expertise* in at least some areas through a combination of coursework and experience in the field.

The question becomes exposure to, and experience and expertise in what? There are few university-based programs that are currently designed to train students to work in settings that fully incorporate the principles and practices of the systems of care model as presented in this document. Although there are an increasing number of interprofessional training programs, a movement that shares many of the principles and practices of systems of care sites, most of the programs are new, small in nature, with few full-time faculty, and generally apart from the ongoing work of the core program. The majority of university programs still train for specialized "within-discipline" professionals. Few "have developed programs with a sufficient emphasis on identifying and solving the complex problems of children and their families in comprehensive, coordinated ways" (Short, 1997, p. 349). The emphasis continues to be on within-discipline expertise in single settings.

The section that follows provides a few examples of programs that illustrate some innovative approaches to training including the program in Community Mental Health at Trinity College in Vermont, the doctoral studies program in child and family policy at the University of South Florida, the Training for Interprofessional Collaboration Project developed at the University of Washington in Seattle, and the clinical child psychology internship program at the University of New Mexico Health Sciences Center.

Trinity College

Based on the Trinity core competencies described earlier, the Program in Community Mental Health offers Certificates (one-year program) and a master's degree (2 ½ years) to staff, managers, consumers, and family members interested in learning the full range of clinical and management skills needed for work in public mental health systems. The certificate constitutes the first year of the master's program. Certificates are awarded in either Clinical Services for Children/Adolescents with Severe Emotional Disturbance and Their Families, or in Clinical Services for Adults with Psychiatric Disabilities.

The purpose of the child-focused program is to: improve service outcomes for children with severe emotional disturbances and their families; increase the competence of staff and managers working with children and their families; develop new leadership related to managed care, cultural diversity, and emerging needs; and increase the number of service consumers and family members in the mental health work force. The first year provides a curriculum pertinent to a family-centered approach and the wraparound process for working with families. The master's program continues with a focus on administration and leadership in community mental health and offers training on community-based systems of care, management, and policy.

The program is designed to meet the needs of adults who are in the workforce or have other full-time responsibilities. The programs are offered at selected sites where student interest and system support are high. Faculty teach at local "learning communities" of professionals, service users, and family members. Formal class time is limited to one weekend per month. Students also learn at home using readings, written assignments, and other specially prepared course materials. The Certificate program includes flexible 250-hour internships in community programs with on-site supervision—500 hours for the master's program. Students complete one course every two to three months. Sites where the program has been offered include Pittsburgh, Pennsylvania, Middletown, Connecticut, White River Junction and Burlington, Vermont, and Milwaukee, Wisconsin.

The program is intended to be affordable and accessible to a broad range of students, though students pursuing the master's degree are required to hold a bachelor's degree from an accredited college. As of fall 1998, there are over 200 master's level students who have been trained or are in training, from a variety of states. (For more information contact: Donna Maloska, (800) 863-6110).

University of South Florida

The University of South Florida in Tampa has a doctoral studies program in Child and Family Policy that leads to a Ph.D. in Special Education, with a specialization in systemic issues relating to children who have, or are at risk for, emotional or behavioral disabilities and their families. The multidisciplinary program is based in the Department of Special Education and the Department of Child and Family Studies at the Florida Mental Health Institute. Collaborative partners in the program include faculty from the Colleges of Public Health, Education, and Arts and Sciences. In addition, local provider agencies and the public schools have joined as partners. The purpose of the program is to prepare persons to assume leadership positions in agencies, public schools, and academia within a context of developing, improving, and evaluating a collaborative, integrated system of care for children who have emotional or behavioral disabilities and their families. The program consists of a core group of basic courses in special education with a concentration of seminars and field experiences focused on research, evaluation, and policy analysis. (Contact for more information: Albert Duchnowski, Department of Child and Family Studies, (813) 974-4618.)

University of Washington—Seattle

A 1995 survey of Interprofessional/Interdisciplinary Training Programs by Portland State University's Research and Training Center on Family Support and Children's Mental Health, identified 25 university professional education programs and 26 agency-based training programs across a range of human services (Jivanjee et al., 1995). One example of such a program is the Training for Interprofessional Collaboration Project developed at the University of Washington-Seattle. Five professional schools joined together in 1991 to develop a pilot project that was recently completed. This collaborative, community-based learning model was available to students in education, social work, public health and community medicine, nursing, and public affairs. Students worked in teams to learn the skills to work with children and families as a collaborative, interprofessional team, as well as with families and the broader community through both classroom and applied learning situations.

Some features of the project included:

- a joint course on collaborative practices cross-listed in all five professional schools, involving seven faculty, four practitioners and as many as 55 students per year.
- partnerships with three different communities and many service agencies to accept and supervise collaborative field placements.
- co-facilitation of student teams by faculty and practitioners.

Faculty faced many challenges in developing the project which mirror some of the challenges of collaborative practice. Among them were the following.

- Translating personal traits into competencies, which in turn could be related to learning objectives, was a formidable task for the curriculum development committee.
- Many university faculty were often not well prepared for the demands of team teaching, which was costly and more complex.
- The blend of experiential and didactic learning required more time of students, faculty, and practitioners - time that was difficult to come by for a course that never became core to any one curriculum.
- There was tension between the goals of student learning and those of community services.
- Maintaining a multi-year commitment on all sides of the partnerships was difficult when there were continual pressures from other sources for change.

As a result of their experience, faculty learned that it was necessary to spread the learning out over time, location, and experiences, and that there was a need for an ongoing base of institutional support and buy-in at multiple levels of faculty and administration. Although the full project and placement structures are no longer operational, the joint course is still offered and materials and placements for core courses in some of the participating five schools have been developed and are being used. In addition, the lessons learned from the demonstration are important for future similar interprofessional endeavors. (Contact for further information: Richard Brandon (206) 543-8483.)

University of New Mexico Health Sciences Center

The clinical child psychology internship program at the University of New Mexico Health Sciences Center is based on a foundation with four cornerstones: 1) a multicultural orientation, 2) within a

developmental framework, 3) in an interdisciplinary department, 4) serving emotionally disturbed children and adolescents and their families in the public sector. The program has adopted a cultural responsiveness model that assumes that culture, regardless of ethnicity, is a central aspect that must be considered in all types of psychological intervention. In addressing cultural responsiveness, the program addresses process rather than outcome and focuses as much on the "therapist" as it does on the "client." The program promotes the practice of psychology within contextual models such as family systems, ecological, and social constructivist (e.g., narrative therapies) interventions, because these models are conducive to viewing culture as an integral and central feature that must be addressed in clinical practice. The program devotes attention to having interns examine themselves in terms of how their culture as experienced in their families and "academic upbringing" has influenced who they are, how they see themselves, and what they value in others. This is done through experientially based seminars and supervision.

Because a large number of the client population come from diverse American Indian and Latino groups, the program utilizes a "cultural consultant list" of service providers from these groups. The role of these consultants, who can be called on by either the intern or the supervisor, is to help educate both the intern and the supervisor on the cultural issues applicable to the case for which the consultant has been called. The program attempts to address not only the cultural awareness of the interns but also that of the faculty as an ongoing process.

Among the competencies that the program tries to foster are the abilities to:

- understand and appreciate one's own belief system as separate from those of the clients;
- understand and appreciate other's belief system and phenomenological perspective, to "see" the problem within the client's paradigm;
- focus on meaning instead of on "facts" or "data";
- conceptualize problems and solutions in more than one paradigm;
- appreciate when culture is ostensibly used as a mask;
- work within what some narrative therapists describe as a "not knowing" stance;
- collaborate and work in partnerships;
- learn from others and to learn together;
- not feel unduly challenged or defensive when questioned; and
- look inward for answers rather than blaming the client for not getting better when we assume we are doing therapy "the right way."

The program also attempts to provide the following through seminars and supervision:

- knowledge of the dominant culture's sociopolitical history and how it has affected what is learned as "truth"; knowledge of general parameters regarding where cultural differences can occur (e.g., wait-time, a sociolinguistic variable, that varies from culture to culture and affects the production of speech in therapy);
- appreciation for how issues of power, privilege, socioeconomic status, and political influence affect clients and therapists;
- appreciation of rural versus urban lifestyles; and
- appreciation of the "cultures" of psychology, psychiatry, and social work. (Contact for more information: Clinical Internship Office: (505) 272-2944, or Luis Vargas, Director (505)272-8798.)

In addition to these innovative programs, there are many discipline-specific programs throughout the country that may not focus specifically on treating children with emotional and behavioral models in a systems of care approach but incorporate certain of the key elements. There are also examples of individual faculty members within more traditional programs who have incorporated training for some of the competencies into their teaching, as illustrated by John Burchard's work at the University of Vermont (see Exhibit 5).

EXHIBIT 5
UNIVERSITY OF VERMONT

John Burchard, professor of psychology, provides examples of how he uses different strategies that reflect the systems of care approach in teaching students in Vermont's doctoral clinical training program:

- Have parents and consumers converse with students about their experiences and recommendations pertaining to service delivery systems.
- Have students do case studies of children in restrictive, residential treatment centers and psychiatric hospitals. They examine how the children got there, what services might have prevented their removal from their families and communities, and whether the services are best practices for community adjustments. Where possible, students conduct interviews with parents, youth, and providers.
- Have discussions about providing services outside professional boundaries and the relationship between boundaries and effective practices.
- Teach students how to conduct comprehensive "strengths-discoveries" as a prerequisite to any assessment of psychopathology.
- Teach students how to develop, implement, and evaluate more natural family and community supports rather than focusing exclusively on professional, therapeutic services.

INSERVICE TRAINING

The goals of inservice training are to: (1) refine or update current skills, (2) acquire new skills, (3) establish the capacity to generalize skills acquired in the training situation to the workplace, (4) refine those skills continually over time, and (5) teach those skills to others. Implied in these goals is an emphasis on outcomes that result in positive practice changes within service delivery contexts.

To achieve these goals requires far more than the traditional approach to inservice training. Having staff attend scattered conferences, workshops, or one-time trainings is never going to be sufficient. Staff development requires a full commitment that is reflected throughout the organization, and is closely tied to program goals, objectives, and priorities (National Staff Development and Training Organization (NSDTA) 1993; Robertson, 1997).

As summarized by the NSDTA, an affiliate of the American Public Human Services Association, the essentials for sound inservice training include the following (NSDTA, 1993):

- administrative support;
- an organizational climate that permits looking at problems and the means to resolve them;
- management's commitment to the value of cooperative planning and the development of ways to work together to meet program and staff needs;
- a realistic understanding by management of what one can expect from a sound staff development and training program, namely that it is not a substitute for good management or a cure-all for every organizational problem or staff deficiency; and
- reinforcement and follow-up of training programs by supervisory and managerial staff.

NSDTA recommends that training be readily available to all staff, that it be provided at sites accessible to the participants, and that direct supervisory responsibility be built in to supplement and reinforce retention and use of new skills.

Two examples of approaches to inservice training that incorporate the principles of adult learning and best practices are from the Hawai'i 'Ohana Case Management Curriculum and the training for Multisystemic Therapy.

Hawai'i's 'Ohana Project

The Hawai'i 'Ohana Project's Case Management Curriculum was created in 1995 as a joint project between the Institute for Family Enrichment in Honolulu, the Wai'anae Coast Community Mental Health Center, Inc., and the 'Ohana Project—one of the Comprehensive Community Mental Health Services for Children and Their Families Program sites. The curriculum was designed to train community professionals with diverse backgrounds to serve as effective case managers for children with emotional and/or behavioral difficulties and their families at the two sites of the Hawai'i 'Ohana Project. (See Chapter V for more information on the Case Management Curriculum.) The following statement, included in their literature that describes the curriculum, provides a clear example of the application of adult learning principles.

From the Hawai'i Ohana Project's Case Management Curriculum:

A variety of learning experiences are used to accommodate diverse learning styles and cultural backgrounds. Learning experiences include small and large group activities, drama (role-playing), visual aides, guided imagery, didactic mini-lectures(20 minutes maximum), sentence completion assessment activities, creative planning, and handouts ... All learning experiences are presented within a nurturing learning environment, built on mutual respect and appreciation for the unique talents and knowledge of each participant. The role of the trainer is based on the premise that learning is a shared experience best accomplished when the teacher empowers and builds upon existing attitudes, skills, and knowledge.

Training in Multisystemic Therapy

Scott Henggeler and his colleagues at the Medical University of South Carolina in Charleston have developed the Multisystemic Therapy model of treatment in working with juveniles who are violent and chronic offenders, and their families. The success of their work is very much dependent on a comprehensive approach to training that embodies many of the principles of successful training for adults addressed above.

The components of their training include:

- a 5-day intensive didactic and experiential training that includes role playing, critical analysis of cases, and problem solving exercises;
- quarterly 1 1/2 day booster trainings to discuss current cases and increase the overall understanding of multisystemic therapy and respond to individual site needs;
- weekly on-site supervision consistent with the model; and

- weekly treatment integrity checks through telephone consultation with an expert in multisystemic therapy that focuses on promoting adherence to multisystemic therapy treatment principles, developing solutions to difficult clinical problems, and designing plans to overcome any barriers to obtaining strong treatment adherence and favorable outcomes for youth and families.

All agency staff with clinical or supervisory responsibility in the multisystemic therapy program attend trainings. In addition, administrators and stakeholders from collaborating agencies attend the first day of training as an orientation to the program's rationale, goals, and procedures.

This intensive approach to training is based on the belief that the effectiveness of the model is dependent on the therapists' fidelity to its principles and practices. Their research has demonstrated that dropping even one component of the training resulted in an overall reduction in the fidelity of multisystemic therapy and in poorer outcomes (Henggeler et al., 1997). These researchers contend that their findings support the view that the lack of fidelity to treatment principles and practices may be a key reason why mental health treatment approaches have had more success in research settings than in community settings. What staff are actually doing in their interactions with children and families may not bear sufficient similarity to what they have learned to do. Although it is costly to provide the full range of training and support, Henggeler and his colleagues conclude that it is more efficient than providing services that are ineffective.

Why Training Fails

A summary of reasons why training fails, recreated in Exhibit 6, is presented below (from an internet document provided through The Applied Research Laboratory at Pennsylvania State University, at : http://quark.arl.psu.edu/training/tr-fails). These reasons were culled from a list of 39 reasons why training programs fail to live up to their promise developed by Dale Spitzer, a consultant on training and organizational development for Fortune 500 companies.

EXHIBIT 6
WHY TRAINING FAILS

1. Training Viewed as Education

In many organizations training is viewed as a form of education and as a result loses its unique contribution to the organization. Training should be aimed at short-term skill development with immediate contributions to improved performance on the job. Its effectiveness should be continually evaluated as part of a larger, long-term, educational goal for the entire organization.

Exhibit 6 (Continued)

2. Training Viewed as a Fringe Benefit

Many organizations view training as a right and privilege for all employees and lose sight of its ultimate performance improvement purpose. Unless performance improvement is the goal of training, it cannot be held responsible for results.

3. Classroom Mentality

For most organizations, training occurs in an isolated, protected environment that is far different from that of the performance environment. It is still dominated by the lecture format and conforms to the general framework of classroom instruction. This prevailing belief that training should occur in a classroom, and away from the job, is one of the reasons why transfer of training from the classroom onto the job is so difficult to effect.

4. Lack of Management Commitment

Managers rarely give more than lip service commitment to training programs. Supervisors and other managers must be willing to actively support the performance improvement efforts through participation and resource sharing.

5. Dumping

Employees are often not expected to integrate the training that they received with their jobs. As a result, training is viewed as an end in itself, which leads to this "dumping" phenomena. *Dumping* means transferring employees from their jobs into training courses and then transferring them back to their jobs without any expectations concerning their responsibilities or accountabilities. Clear goals and objectives must be established to make the training job-relevant.

6. Too Much Emphasis on Development and Delivery

If trainers spend too much time on developing and delivering training courses and too little time interacting with the client unit, the results can be disappointing. Appropriate emphasis should be placed on needs analysis, consulting assistance, and follow-up after training to maximize performance improvement on the job.

7. Lack of Performance-Based Evaluation

When training evaluation techniques focus on satisfaction indices only and not on other factors such as performance and impact of the training on organizational results, training will remain little more than entertainment. New accountability mechanisms need to be established that measure the trainees' transfer of training capabilities.

8. Too Much Content Is Covered

Current training techniques tend to cover too much information in any given curriculum. There is always a tendency to add "just one more topic". In order for training to be effective in improving

Exhibit 6 (Continued)

performance, it should be trimmed down to a manageable size to allow the trainee to process the content in a meaningful manner rather than simply retaining the information in its concrete form.

9. Focusing Exclusively on Knowledge Objectives

Too much training is primarily information-centered and not skill-centered. In an applied performance environment, training professionals must guide subject matter experts to unravel the relationships between knowledge and skill because increased knowledge without skills will rarely contribute to improved performance and organizational results.

10. Inappropriate Trainees

Inappropriate selection of trainees can be a waste of time for the trainees, the trainers, and the organization. Often the wrong population of trainees is selected for a particular training program. They either don't want the training, don't need the training, do not possess the necessary prerequisites, or will not have the opportunity to use the new skills on the job.

11. Lack of Follow-Up after Training

For the most part, trainers see their responsibilities ending when the training is over. This lack of follow-up by the trainers leaves a big question mark as to how the training is being implemented on the job and whether the skills have been appropriately transferred. It is critical to performance improvement that trainers begin to see their role as a continuing one.

12. Constraints in the Performance Environment

Performance environments can create obstacles and barriers that may be insurmountable without the support and commitment of management and training personnel. Negative effects due to disincentives, unclear expectations, lack of interpersonal support, and poor supervision can greatly diminish the effects of training programs.

EVALUATION OF TRAINING

Although billions of dollars are spent annually on training, the methods for evaluating training are not well developed. There is an assumption that training is valuable but we rarely go beyond the typical reaction/satisfaction questions that participants complete at the end of training sessions. To know whether training is effective, other questions need to be addressed, including:

- Does the training target the knowledge, skills, and abilities critical to job performance?
- Does learning occur during training?
- Does the training result in a positive return-on-investments?

- Does the learning transfer to the work site and is it maintained and generalized?

The most common approach to evaluating training usually includes the four-level approach (Curry, 1996):

1. *Participants' reaction*—the level of satisfaction, usually assessed at the conclusion of the training.

2. *Learning*—the extent of learning as a result of training usually measured at the completion of training, or through pre- and post-testing.

3. *Behavior*—the extent to which changes are transferred to the working situation, generally three months to one year after the training. Three months is cited as the key time to show that behavior change has occurred. Mechanisms for measuring transfer of training have included reports from supervisors, interviews, focus groups, surveys and questionnaires to trainees, supervisors, subordinates, and peers, use of action plans, observations, performance appraisals, and utilization of self-reports.

4. *Results*—the amount of impact on the organization, personnel or consumers.

The National Staff Development and Training Organization lists the following mechanisms, similar to the levels above, for assessing the effectiveness of staff development and training activities: gathering participant reactions through post-training questionnaires, pre/post tests of skills and knowledge, trainer observation, supervisory review of performance after training, peer review, changes in quality control findings, process recordings, role playing and scenarios to assess performance level (NSDTA, 1993).

CONCLUSION

The preceding chapters have addressed both the content and process of training necessary to effectively change the practice of staff who work with children and families in systems of care. What should be clear from the review of the literature and discussion is that it is necessary to define training as part of an ecological system that involves multiple elements that change over time—not as a one-time event. One has to consider factors that occur before, during and after training, as well as the person being trained, the training itself, and the environment in which the trainee applies his or her skills, knowledge, and attitudes.

A person brings his or her skills, motivational level, ability to learn and apply knowledge, and learning styles, along with age, education, and life experiences to a training experience. A training event, whether a preservice program or a one-time workshop, can be characterized by the content of what is taught, the principles of learning that are used, and the process of preparing for, conducting, and evaluating the training. The ability to transfer the learning that occurs in training is dependent on a number of factors in the environment in which a person works, such as supervisory support, opportunity to use the training, and organizational goals and commitment. Exhibit 7 summarizes this array of elements that can be considered as having an influence on the effectiveness of training in leading to a change in practice (Curry, Caplan, & Knuppel, 1994).

EXHIBIT 7
AN ECOLOGICAL APPROACH TO TRAINING: THE COMPONENTS TO EFFECTIVE TRAINING

I. TRAINEE

- Competence
- Life experiences
- Motivational level
- Sense of efficacy
- Ability to learn and apply knowledge
- Personality-attitudes and values
- Age
- Level of education

II. TRAINING

- Principles of learning
- Amount of practice
- Content
- Sequencing of activities:
  - Needs assessment
  - Developing training objectives
  - Designing curriculum
  - Designingselect training materials
  - Design evaluation approach
  - Conduct training
  - Measure results

III. TRAINEE ENVIRONMENT

- Administrators – value placed on training
- Time constraints
- Organization's training goals, roles, rules, expectations of trainees
- Congruence between training and work environment
- Opportunities to use training
- Positive message from others about utility of training
- Supervisory support

The next chapter provides a detailed description of North Carolina's Pitt and Edgecombe-Nash Public Academic Liaison *(PEN-PAL)* Project, a comprehensive approach to preservice and inservice training that applies the principles of adult learning and the values and content of the systems of care approach.

Chapter V
The North Carolina Pitt-Edgecombe-Nash Public-Academic-Liaison *(PEN-PAL)* Project: One State's Comprehensive Approach to Training[1]

North Carolina's Pitt and Edgecombe-Nash Public Academic Liaison *(PEN-PAL)* Project illustrates how one state has applied many of the concepts described in previous chapters. The goal of the project is to change service delivery and practice to be more consonant with system of care principles and strategies.

BACKGROUND

North Carolina's Pitt and Edgecombe-Nash Public Academic Liaison *(PEN-PAL)* was funded in February 1994, by the Center for Mental Health Services, as one of 22 national Comprehensive Community Mental Health Services for Children and Their Families Program sites. The project's primary objective is to establish a comprehensive community-based system of care for school-aged children and adolescents with serious emotional disturbance, who are at risk for or placed out of the home, and their families. Full and active partnership with family members and among all child-serving agencies in all aspects of project implementation, management, and evaluation is a primary goal for the project. Services have the goal of maintaining children in their homes, providing services in the least restrictive setting, discouraging service dependence, encouraging children and families to become involved in naturally occurring community supports, and optimizing the value of services provided.

The project is based on the belief that there are three elements important to the development and management of a high quality community-based, interagency/community system of care:

1) a shared philosophy among agencies, families and community;

[1]This chapter was written by Martha C. Kaufman, M.A., State Project Manager for the *PEN-PAL* Project. She works for the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Child and Family Services Section. Others who helped with the chapter review and editing are listed in Appendix A. For more information contact: Martha Kaufman at (919) 733-0598.

2) a multiagency/community infrastructure for service planning and delivery;

3) preservice and inservice training and technical assistance for providers, family members, university faculty, students, and other community stakeholders that promote learning and application of the values, attitudes and skills necessary for implementation of a system of care.

To implement the project, *PEN-PAL* utilizes a three-tiered interactive service and management structure:

- At the core of the system are *Individual Service Teams (ISTs)*. These teams are built around each child and family upon entry into the project, and are comprised of immediate and extended family, participating agencies, and community and neighborhood representatives involved in the everyday life of the child and family.

- *Project Management Committees* in each catchment area were established to drive system implementation and evaluation while supporting the work of the Individual Service Teams through coordination of local policy and procedures, integration of local funding streams, and problem resolution.

- A *State Oversight Committee*, comprised of key representatives from family advocacy groups, state and local child-serving agencies, and East Carolina University faculty, provides state level policy integration and coordination, and assistance to the local management committees to ensure the success of Individual Service Teams.

At each level, *PEN-PAL* strives to have family members and representatives of family advocacy and support organizations participate as full and active partners in all levels of the service and management structure, including involvement in the conceptualization and presentation of preservice and inservice training.

In recognition of the important role of academic training programs in preparing professionals to work in the public sector, the need for state-of-the-art training approaches, and the desire to build a broad community-inclusive effort to implement a system of care, faculty from East Carolina University (part of the University of North Carolina System) became partners in development and implementation of the *PEN-PAL* Project. Faculty from six university schools and departments participated, including the College of Arts and Sciences, Department of Psychology; the School of Education; the School of Human Environmental Sciences, Marriage and Family Therapy Program; the School of Medicine - Child and Adolescent Psychiatry; the School of Nursing; and the School of Social Work. These faculty formed the East Carolina University Social Sciences Training Consortium to work with project staff and community stakeholders to

develop state-of-the-art curricula, and provide training and consultation to service providers, family members, community representatives, and university graduate students. (A description and qualitative study of the Consortium's formation and initial year of operations is provided by Powell et al. (in press)).

The goals of the Consortium are to:

- become familiar with systems of care philosophy and with the services and mode of operation of participating agencies;
- become familiar with and build understanding about consumer and family member needs and point of view as service recipients;
- become familiar with the unique skills, attitudes, and knowledge that are required to implement the project's system of care;
- integrate these perspectives to develop preservice and inservice curricula that incorporate system of care philosophy, values, and practices;
- inform project participants on state-of-the-art theory and practice in the scholarly literature from the fields of study represented in the Consortium;
- provide clinical expertise and support to staff of the agencies involved in the project through consultation and technical assistance activities.

CHALLENGES

The Pitt Area Mental Health, Developmental Disabilities and Substance Abuse Program, serving one of the target sites, had a strong and positive relationship with numerous East Carolina University faculty. These relationships, however, were based on a history of discipline-specific consultation and student field placements through several graduate training programs. As a group, faculty contacts with agencies in other systems, including social services, public health, public schools, and juvenile justice agencies, were more limited.

Both faculty and providers were unevenly versed in system of care principles and their application. There were also clear differences among family, provider, and community perceptions regarding best practices, as those on the front lines struggled to develop their understanding of what constituted effective practice on a daily basis in the field, while university faculty were more often exposed to best practice ideas through their discipline-specific literature.

At the beginning of the *PEN-PAL* project, there was no local family advocacy organization comprised of family members of children with serious emotional problems. It was a challenge to simultaneously institute an ambitious services system reform, constitute a management structure, develop a training program, assemble a university consortium, and promote the development of an independent family and advocacy organization.

The following basic questions emerged from these challenges:

- *Could university faculty who did not "live" in the field, develop adequate training for providers who were breaking new ground in non-traditional care?*
- *How could faculty become learning partners with families and providers, given their central identity and role as instructors?*
- *How could family members and front-line providers become comfortable as 'learning by doing' peer experts?*
- *How could providers, families, and university faculty mutually redefine "state-of-the-art" practice and training?*
- *How should training curricula be developed, delivered, and evaluated in a truly collaborative way?*
- *How could the project ensure training responsibility in a fluid systems reform effort?*

Understanding Agency, Family, and University "Cultures"

Promoting understanding of the skills, attitudes, and knowledge required to implement the system of care was a challenge for all project participants. Providers worked cooperatively across agency lines, but had limited knowledge and appreciation of the mandates and customs that constituted their sister agencies' cultures and characterized their practice. Families, agencies, and faculty had little experience in developing working partnerships that were truly family-inclusive. Successful collaboration among providers, families, university faculty, and other community stakeholders, however, required understanding and resolution of their inherent cultural differences. Finding common ground and respect for the differing values that each brings to the collaboration was difficult and time-consuming, but critical to success. This collaborative work was accomplished through a process of local agency assessment described in the next section.

Local Agency Asset Assessment Study

One of the first efforts to promote understanding and appreciation of the underlying values and cultures of the child-serving agencies occurred through the development of the *PEN-PAL* Local Agency Asset Assessment Study, developed by state project office staff at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' Child and Family Services Section. The Local Agency Asset Assessment Study had several goals:

- increase understanding of university faculty regarding the day-to-day reality of front-line service delivery and administration in social services, schools, juvenile justice, health, and mental health agencies;
- build trust between providers, administrators, and university faculty;
- establish a baseline of understanding and application of system of care principles in child-serving agencies, utilizing a strengths-based approach;
- identify and disseminate information regarding hidden strengths within daily practice and administration of child-serving agencies;
- identify training and technical assistance activities necessary to integrate system of care philosophy and practice into the service system.

Two protocols were used in the study. The first questionnaire was designed to assess the congruence or lack of congruence between the agency's policies, administration, and service system and system of care principles. The second protocol was an observation tool designed to gather information regarding congruence or lack of congruence between everyday practice by agency providers with system of care practices. This protocol was used by the faculty member as he or she shadowed a front-line provider and observed a "typical" case review meeting regarding children and families receiving agency services. Both protocols were designed to elicit information regarding the strengths of the agency, with the underlying assumptions that all agencies have positive policies and practices that can contribute to the implementation of a system of care, and that these strengths may go unrecognized because they are part of everyday operations and have not been examined as contributors to an integrated service system.

Process

Each participating Consortium faculty member was matched with an agency representative. Matches were made to bridge traditional lines. For example, faculty in nursing were paired with staff from a child welfare rather than public health agency. Each faculty/agency representative pair met to discuss the purpose, scope, and protocol for the assessment. The agency representatives provided information about

their agency such as its mission statement and organizational chart. They also identified and prepared participants for the shadowing activities in a way that would most represent a "day in the life" of the agency, in the least obtrusive manner. Upon completion of the two activities, faculty met again with their agency partners and the staff they had shadowed to discuss observations, training, and technical assistance issues. A final report of observations, service and administrative learnings, training, and technical assistance implications was reviewed by all participants and presented to the Projects Management Committee. To further promote recognition of agency strengths and share knowledge gained from the study, a project-wide Best Practices Institute was held as a retreat in the summer of 1995.

Results

As hoped, all project participants understood better the culture and customs unique to each agency, and the strengths each could bring to the collaboration. Faculty and agency staff reported a marked increase in mutual trust and personal connectedness, with a concurrent increase in informal consultations. Providers became more actively involved in shaping training and technical assistance plans. Faculty grew more knowledgeable and appreciative of the day-to-day world of agency administration and service delivery, and of gaps between existing agency mission and practice that could emerge as barriers to system of care goals.

The Agency Assets Assessment Study improved understanding and appreciation of agency and university cultures. However, an even more active partnership between faculty trainers and those who received their training was needed to ensure that the content of training was relevant to family members, community representatives, agency administrators, service providers, and students preparing for work in the public sector.

Shaping Training Content and Methodology

In the spring of 1995 a group evaluation process was initiated to increase trainee impact on training and technical assistance. It was agreed to spend 30 minutes after each training event on an evaluation of the training session. After an overview of the evaluation process, including purpose and procedures, trainees were divided into small discussion groups to generate feedback on content and methodology of the training, using a Group Training Evaluation Form. The individual and group evaluation forms were provided to the Consortium, who reported back to trainees at the next training event as to how their feedback was incorporated into the current session.

In addition, to ensure full participation of family members, community representatives, and agency providers in the design and delivery of training, the Training and Technical Assistance Process document (TTAP) was developed. A two-part document established a framework to systematically solicit input regarding proposed training and related products, and to report on results or outcomes related to the training or product. Utilization of the TTAP established "blueprints" of process and products expected to be valuable in replication efforts at other universities.

Continuing Education for Faculty

One of the greatest benefits of *PEN-PAL* was the opportunity for faculty to attend system of care conferences and training events. Consortium members received travel support to attend meetings such as the Training Institutes sponsored by the National Technical Assistance Center for Children's Mental Health, and annual meetings of the Federation of Families for Children's Mental Health. Faculty also attended local workshops presented by consultants brought in by the project on such topics as wraparound approaches, school-based wraparound services, and cultural competence. These opportunities informed faculty of systems of care research and literature, exposed them to leaders in the field, and provided occasions for them to be learners along with service providers and family members. This continuing education sparked further reading and resource gathering by faculty, which fueled curriculum update and new course development. In addition, it sparked new ways of thinking about practice in the field and influenced the applied work, service provision, and supervision provided by the faculty.

DEVELOPING INSERVICE AND PRESERVICE TRAINING

In the third year of the project, a full-time resource center was created to meet the needs of a growing demand for inservice training, to coordinate an expanding cross-agency training schedule, to respond quickly to emerging training needs in the field, and to fully engage families and service providers in the development and delivery of training. The *PEN-PAL* East Carolina University Training and Technical Assistance Resource Center was established to address these needs through a partnership with the School of Education and the School of Medicine—Department of Child and Adolescent Psychiatry. At the same time, the faculty participating in the Social Sciences Training Consortium intensified their work in the preservice area as they expanded the number of courses into which system of care principles were integrated, implemented a new graduate course, and developed a field placement handbook to promote cross-agency practice experiences for students.

Preservice Activities

One of the main purposes of the Consortium has been to help prepare students in preservice professional training programs in child and family serving fields to work effectively in a collaborative, integrated system of care for children who have emotional/behavioral disabilities and their families. This purpose is achieved through: (1) infusion of system of care principles into existing course work; (2) supervised field placements for students in child-serving agencies who are delivering services through Individual Service Teams; (3) the development of a graduate course in collaborative theory and practice; and, (4) national presentations, publications in professional journals, and dissemination of products. To this end, the following activities and products have been developed and continue to be refined:

- ***Family Inclusion – "Parents in Residence"***. Parents of children receiving services and participating in the local family support and advocacy organization, *WE CARE* (With Every Child and Adult Reaching Excellence), work with the university as "Parents in Residence." Through a contract between the university and the family organization, family voice and perspective are promoted in all curricula design and delivery, evaluation, and quality improvement activities. All aspects of family participation in training described below are achieved through the Parents in Residence process. For a further description of this work, see *New Roles for Families in Systems of Care*, Volume I in this same series of monographs (Osher et al., in press).

- ***Integration of System of Care Principles into Core Curricula***. Core courses for each professional discipline are updated and revised to include theory, principles, practices, and ethical concerns related to implementing a community-based system of care. Didactic and experiential components are included so that students gain experience in current public sector service models (use of community support systems and wraparound services) and philosophy (focus on strengths-orientation and new roles of service users and family members). Products for each course include: a detailed course syllabus including revised course objectives, course content, lesson plans, annotated bibliography, teaching methodology and process, evaluation strategies, as well as copies of the original course syllabi and a brief summary highlighting revisions. Products and processes developed by the *PEN-PAL* Project are used in instruction. Input from family members, family advocates, service providers, and other community representatives are included in all materials and processes. Family members and advocates as well as service providers assist in instruction as visiting faculty. Sixteen courses across four disciplines have been infused with system of care principles (e.g., Family Therapy Theories (Marriage and Family Therapy), Behavior Therapy (Psychology), Nursing Care for Families: A Systems Perspective (Nursing), and Advanced Practice with Families and Children (Social Work)).

- ***Interdisciplinary Graduate Course on Collaboration***. A new interdisciplinary course is being offered at the graduate and senior undergraduate level. The course is cross-listed in all the Consortium departments. The course is team taught by Consortium faculty, with family and service provider representatives serving as visiting faculty. Students, family members and service providers may enroll, increasing their common frame of reference. This syllabus will be made available to other North Carolina universities interested in interdisciplinary efforts.

- ***Cross-Agency Field Placements***. Field placements of students in system of care settings increase students' exposure to and participation on family centered, community-based, interdisciplinary and interagency teams. A Collaborative Field Placement Handbook, currently under review, provides a common framework for supervision procedures, demonstration of competencies, preparation for site supervisors, and evaluation criteria for students from multiple disciplines and site supervisory staff.

- ***A Bartering System***. As an incentive for agency staff to donate time as visiting faculty for classroom instruction, an informal bartering process has been established. Consortium faculty provide consultation to Individual Service Teams in exchange for time with provider staff. Providers donate their expertise through participation in academic classes, review of curricula, and working with practicum and internship students. Faculty offer observations regarding implementation of the system of care, support and encourage participants, and make recommendations for training and technical assistance. This arrangement also exposes faculty to the field, ensuring that their instruction is reflective of daily practice innovations and challenges.

- ***Dissemination***. Consortium faculty submit proposals for presentations to professional associations, prepare manuscripts for publications in professional journals, participate on relevant professional association committees (e.g., American Psychological Association work group on innovative training approaches for psychologists working in the public sector), and make syllabi and other course products available to other university faculty.

Inservice Activities

Through the *PEN-PAL* Training and Technical Assistance Resource Center, the School of Education and the School of Medicine - Department of Child and Adolescent Psychiatry provide intensive training and technical assistance for and with service providers and families. A School of Education faculty member serves as director of the Resource Center, ensuring application of effective adult education learning principles, attention to personal and professional development strategies, and overall coordination of all collaborative training and technical assistance activities. Consistent with a collaborative philosophy, decisions regarding the quantity, audience, type and content for training and technical assistance activities are made in concert with the Projects Management Committee, family members, service providers, and the larger community.

The following activities and products have been developed and continue to be refined:

- ***Training Certification and Information Database***. A graduated trainee/trainer certification process based upon core competencies, to assist participants in increasing their current skill level and structuring their individual professional development, is under development. "Basic," "Advanced," and "Trainer" curricula will target emerging skill development and interests of participants over time. A Training Information System database housed at the Resource Center provides information regarding requirements for certification or credentialing for staff interested

in gaining this expertise, for agencies and organizations interested in promoting practice changes for their staff, and identifies participants with specific expertise in system of care principles and practice for peer consultation.

- ***Training Delivery and Practice Support***. Peer Trainer Teams, comprised of family members, family advocates, and multiagency service providers, model collaboration as they provide training to new participants across the state. A four-phase, inservice training delivery process is used to promote understanding and application of system of care principles:

  1) Peer Trainer Teams utilize a community mobilization and "kick-off" curriculum called "Together We Can Weave a System of Care" (adapted and refined from a curriculum developed in Hawai'i) to introduce system of care concepts to new communities;

  2) A four-module Core Training Curriculum that includes pre-assessment of participants' attitudes and skills, along with pre-reading assignments, provides skill-based instruction on Individual Service Team participation, application of the wraparound process, development of strength-based plans, and development of Individual Service Plans for all participants;

  3) A manual to assist Individual Service Team (IST) participants in daily practice, the "IST Coordinators Handbook," has been developed; and

  4) Coaching and mentoring through Individual Service Team Practice Groups provide additional support to promote best practices in the field.

- ***Technical Assistance, Knowledge Dissemination, and Coordination.*** A portable library and comprehensive directory of technical assistance through consultation from trainers and mentors, along with state-of-the-art printed materials, videotapes, audiotapes, and compact discs, is available to the communities interested in developing a system of care. Information may be sent by fax, mail, or the Internet. Three newsletters promote dissemination of current information related to system of care development: one targets the *PEN-PAL* site; another, the SOC Update, targets additional communities in the state; and a third, EnVisions, targets family members interested in system of care development. The EnVisions Newsletter is developed and disseminated by the *WE CARE* Family Support and Advocacy Organization.

- ***A telecommunications network*** developed in collaboration with the School of Education's Library Sciences Department allows participants to electronically communicate, access information on training opportunities and best practices, and discuss relevant issues at local, state, and national levels. Provider agencies and family advocates utilize electronic mail and listservs to ensure rapid communication. A *PEN-PAL* World Wide Web Page and chat room are under development to further promote communication and access to project-related tools and curricula.

- ***Training Evaluation and Quality Improvement.*** A comprehensive training evaluation process is being developed to assess and track participant attitudes and behaviors with the system of care. Pre- and post-assessments are used to determine the effectiveness of the training provided. Trainers and curriculum developers review evaluation results along with data from the project's quality improvement processes to assess the effectiveness of training models,

improve training, and identify new training efforts to support best practices. This information is used to address emerging needs on an ongoing basis and to shape training content and delivery in university contracts each year.

- ***Dissemination.*** Along with their colleagues in the Consortium, School of Education and Department of Child and Adolescent Psychiatry faculty submit proposals for presentations to professional associations, prepare manuscripts for publication in professional journals (e.g., Handron et al., 1997), and participate on relevant professional association committees. The Director of the Resource Center, a local elementary principal, and the Executive Director of *WE CARE* have participated as a team on a federal Department of Education subcommittee studying family partnerships in public education.

SYSTEM OF CARE AND PUBLIC ACADEMIC LIAISON EXPANSION

As the *PEN-PAL* Project entered the fourth of its five years of federal funding, the principles and practices upon which it is based were refined sufficiently to allow for expansion into other areas of the state. In 1996, Buncombe, Moore, Cleveland, and Guilford Counties were designated as System of Care Expansion Sites, including a new public-academic-liaison with the University of North Carolina at Greensboro and Guilford County called GIFTTS (Guilford Initiative for Training and Treatment Services).

The Center for the Study of Social Issues at the University, in partnership with the state office, established the GIFTTS initiative. The Center built upon the work of *PEN-PAL* to create training and services specifically for the Guilford County region. In early 1997, GIFTTS broadened their initiative through a partnership with North Carolina A&T University (a historically black university). GIFTTS works collaboratively with local public and private provider agencies, family members, family advocates, and community representatives to develop and provide inservice and preservice training promoting system of care implementation.

As other universities, colleges, and communities expressed a growing interest in joining these initiatives, the Division of Mental Health's Child and Family Services Section developed a comprehensive plan to support expansion, leading to an interactive regional System of Care(SOC)/Public Academic Liaison system across the state. A statewide Public Academic Liaison Coordinator position to link and coordinate universities, colleges, and participating communities was created in 1997 to implement this plan.

CRITICAL COMPONENTS

The experience in North Carolina has contributed to a greater understanding of the optimal components for the promotion of system of care principles and practices in preservice and inservice training. They include:

- integration of system of care principles and practices into numerous existing courses across professional disciplines in order to expose large numbers of students to these concepts;

- multi-agency field placements in community sites to demonstrate system of care practices associated with classroom instruction, provide students the opportunities to practice new skills, and assist service providers in the service delivery process;

- development of courses in collaborative theory and practice that are team taught by faculty across professional disciplines, along with family members and community providers to model and promote a deeper understanding of these concepts;

- promotion of collaborative state and national presentations to model system of care concepts and provide recognition to presenters; and

- promotion of publications in professional journals to influence the field of practice and support faculty in meeting university publication expectations.

Optimal processes to support public academic partnerships in the development and delivery of preservice and inservice training include:

- a cross-school/department consortium structure to ensure a strong interdisciplinary focus and process;

- a direct and active partnership with a system of care site to ensure active family, agency, and community participation;

- geographic proximity of university to service site (distances exceeding an hour commute are generally impractical because of student and faculty travel to field placement sites);

- internship programs to allow for multiagency field placements for the participating schools and departments; and

- expansion of the Parents-in-Residence model.

LESSONS LEARNED

Lessons learned through the implementation of the *PEN-PAL* Project have contributed to a growing understanding of what it takes to support the development of a local system of care. The greatest lesson has been the importance of partnerships between the university, the community, and families. Just as no one

agency can meet the complex and changing needs of a family with a child with serious emotional disturbances, the magnitude of change required at the system, program, and practice level for implementation of a system of care demands commitment and innovation from a rich cross-section of the community.

North Carolina can now begin to answer the questions that were posed at the beginning of this chapter.

Could university faculty who did not "live" in the field, develop adequate training for providers who were breaking new ground in non-traditional care?

Yes, under the following conditions: training provided by university faculty must be grounded in the practice innovations that occur daily in an emerging and nontraditional system. Service providers and family members must be full and active partners in the development and delivery of training. In the *PEN-PAL* Project, this occurs through the involvement of faculty and their students as supports to Individual Service Teams, through participation of service providers and family members as co-instructors for inservice and preservice training, and through integration of preservice and inservice curricula—each reflecting innovations emerging from practice and a growing body of professional literature regarding the system of care.

How could faculty become learning partners with families and providers, given their central identity and role as instructors?

Regular participation in collaborative governance teams promotes a reframing of university organizational and faculty role boundaries, building ownership across all parties toward implementation of one unified system for children and their families. The various strengths, needs, and customs of families, state and local agencies, and universities—when recognized and respected—become engaged in a "win-win" relationship to forge systems change. The strong voice of family members and other leaders in governance teams and a willingness to confront problems and mistakes together without blame, helps ensure that agencies and organizations do not revert to old patterns of isolation and turfism.

How could family members and front-line providers become comfortable as "learning by doing" peer experts?

As providers, families, and faculty coalesce as service and governance teams, previously held notions regarding identity of "experts" begin to change. Families are viewed as experts regarding their children, and service providers are viewed as experts regarding their practice and innovations through the Individual Service Teams. Faculty actively seek to enrich their training and instruction through the active

participation of families and providers, equalizing a previously hierarchical structure that cast them in the only expert role. Given experience and support to work as co-instructors, the norm shifts to collaborative training and instruction for all parties.

How could providers, families, and university faculty mutually redefine "state-of-the-art" practice and training? How should training curricula be developed, delivered, and evaluated in a truly collaborative way?

As noted above, routine team-based service delivery and governance begins to shift expectations toward collaboration for all parties. Training, practice, evaluation, and governance must all come to be viewed as integral parts of a whole, promoting a continuous quality improvement expectation throughout the project. "State-of-the-art" may best be conceptualized as that which not only reflects emerging best practice content, but strongly models system of care principles through co-instruction and teamwork, for instance, the importance of family inclusion in a system of care is best conveyed by a family member in the role of co-instructor.

How could the project ensure training responsivity in a fluid systems reform effort?

Training curricula and other products developed to support the system of care are all considered to be in draft form—inviting feedback and refinement with each use. These products are field tested for 6 to 12 months, then revised to reflect feedback and findings—creating a set of tools that are designed to encourage and incorporate innovation.

The availability of funding and the support for innovation to promote local systems of care at the state and federal level have created a fertile environment for collaboration. Communities, universities, families, and agencies have a unique opportunity to pioneer and embrace new systems on behalf of children and families. Thanks to this favorable climate, North Carolina will continue expanding its system of care and Public-Academic-Liaison initiatives across the state, to promote the success, safety and permanence of children and families in their homes, schools, and communities.

Chapter VI
Promising Approaches to Training: Santa Barbara, Vermont, Hawai'i and Houston

Each community and each agency is unique and ultimately will have to design a training approach that fits its context and its needs. This chapter provides some examples of approaches that incorporate lessons from prior chapters and apply them in a system of care setting. The examples illustrate different types of training in various types of settings: a county (Santa Barbara), and a state (Vermont), both of whom are service sites for the federal Center for Mental Health Services (CMHS) Comprehensive Community Mental Health Services for Children and Their Families Program; and two programs for training community members to work with families, one in Hawai'i (also a CMHS Service Site) and the other in Houston, Texas. The chapter provides an overview and brief description of each program with some accompanying materials available in the appendices, and concludes with some advice for readers gathered from people in the field who are designing and/or implementing training in the comprehensive service sites.

SANTA BARBARA, CALIFORNIA MULTIAGENCY INTEGRATED SYSTEM OF CARE (MISC): A COUNTY APPROACH TO CROSS-SYSTEM TRAINING

Contact for further information: Neal Mazer (805) 681-4093

Santa Barbara County is in its fifth year of implementation of a model for the integration of services for children and youth with serious emotional and behavioral problems and their families. In the course of their work, project staff found that new skills were necessary to effectively implement their vision of an integrated, community-based and family-centered service system which they call the Multiagency Integrated System of Care. Similar to the experiences described in earlier sections of this monograph, they found that the preparation of people at all levels of service was not adequate. Neal Mazer, System of Care Development Specialist, designed their training program based on the conviction that previous professional and clinical training has failed to prepare workers with the 'life skills' and professional skills now needed. These skills include facilitation, mediation, and systems thinking. He views these skills as needed at all levels of policy, program planning, and management (including monitoring and quality assurance), and service delivery.

To address the need for staff to have these skills, the project has developed a cross-system training and mentoring system for staff in Santa Barbara County's mental health, public health, social services, probation, education, and other child-serving agencies. The goals of the training are the following:

- acknowledging and letting go of the pain and frustration associated with working in "broken" systems;
- affirming skills, sensitivity, and experience;
- building and reinforcing work relationships based on shared goals and values;
- building a team that involves all participants: families, receptionists, patient coordinators, and counseling staff;
- supporting the development and application of hands-on skills; and
- creating a philosophical transformation.

Key features of their approach to training include the following:

- They use a set of core competencies adapted from those developed by Trinity College (See Appendix B).
- Families are involved as trainers in all staff development and training activities.
- An initial intensive six-day team building and core training is provided for all staff involved with Multiagency Integrated System of Care that includes a combination of: didactic presentations, small group discussions, group process exercises, cross-system job shadowing, fieldwork, and service plan development. All agency staff are included in the training including supervisors, clinical, administrative, and clerical staff. The sessions are offered either over six consecutive days or two three-day sessions over two weeks. (See Appendix E for the complete agenda for this training.)
- Ongoing, hands-on skills building is available through small groups that meet to review cases on a weekly basis for four weeks, and ongoing coaching takes place through weekly subteam meetings. Skills addressed include thinking (creative, constructive, critical), problem solving, relationship-building, conflict resolution, and communication.
- The project has established a partnership with the University of California-Santa Barbara's School of Education. Faculty and graduate students in the School's joint counseling/clinical/school psychology doctoral program assist with the Multiagency Integrated System of Care evaluation and provide training to agency staff about evaluation and how results can be used to inform clinical practice. The exposure to the application of systems of care practice provides feedback to the faculties' clinical teaching.

VERMONT'S FAMILIES FIRST TRAINING AND TECHNICAL ASSISTANCE PROJECT

Contact for further information: Sherry Schoenberg (802) 229-4554

Families First, formerly called the Access Vermont/Families Preservation Initiative, was developed to design and coordinate all training and technical assistance activities to support Vermont's statewide initiative funded through the federal Center for Mental Health Services' Comprehensive Community Mental Health Services for Children and Their Families Program. The goal of Families First is to support effective service delivery through the development of training and technical assistance activities that enhance the skills of all stakeholders involved in the system of care for children and adolescents who are experiencing a severe emotional disturbance and their families. All the training and technical assistance activities of the Project promote and reflect the values and principles of the system of care: strengths-based, family-centered, culturally competent and individualized.

The project works with regions within Vermont to develop specific local training activities, creates peer support and information sharing networks for specific populations and constituencies, collaborates with the Vermont Department of Education BEST Initiative (Building Effective Supports for Teaching Children with Emotional and Behavioral Challenges) to support training for schools and communities, and develops curricula on priority areas to be used as self-study training for staff and others.

> *"Training is not just about skill building but relationship building."*
> — Sherry Shoenberg, *Families First*, Vermont

Based on the results of a training needs assessment conducted in 1995, an interagency advisory committee recommended priorities for training. The training itself was contracted out through a request for proposal process to the Center for Community Change of Trinity College. The Center then conducted key informant interviews with stakeholders to clarify the training priorities and developed a comprehensive training plan.

The following five principles and elements characterize Families First activities:

- ***All training and technical assistance activities are provided in response to priorities identified by and in collaboration with stakeholders in the system of care.***
  Initial input was gathered through two Training Needs Assessments conducted in 1995 and an Interagency Training and Technical Assistance Advisory Board that shaped the initial plan for training and technical assistance. The Families First Coordinator conducts ongoing training needs assessments through key informant interviews with system of care stakeholders and constituency groups to clarify training priorities. For specific training events, interagency planning committees identify the priorities of their constituencies.

- ***Family member participation in planning and training is promoted and strongly encouraged.***
  Many of the training activities to date have been identified by family members as high priority training needs. Parents are part of all panel presentations and often are co-trainers with providers on certain topic areas. Careful attention is made to include parents in a "real" way as opposed to "token" participation. Parents receive payment for presentations. Youth in treatment have presented at conferences, usually telling their "stories" in ways that promote the importance of being treated with respect, sensitivity, and warmth. When unable to attend for clinical reasons, they have presented their stories through videotape. At one conference, workshop participants provided feedback to the youth who were video taped through videotaping their own reflections to send back to the youth. Training brochures are sent to mailing lists of parents involved with two Vermont parent organizations. The brochures indicate the availability of scholarships for parents to attend trainings. Transportation and stipends for child care can often be arranged. Audiotapes are made available to family members (and others) who do not attend the trainings. The Vermont chapter of The Federation of Families for Children's Mental Health is recruiting and training parents about advocacy and services in the System of Care. Further, they are developing a training video series that will be more accessible to parents who are unable to attend training events.

- ***Relationship building, collaboration, and ongoing networks for support and information sharing are key ingredients.***
  The Training and Technical Assistance Project staff have strong relationships with local constituencies to help them assess needs identified by local groups and to assist them in implementing activities. Special populations such as school and mental health clinicians and children's crisis workers have formed peer networks that are staffed and supported by Families First. Regularly scheduled meetings of these networks provide helpful support, ideas and information about best practices. Project staff also work in close collaboration with the Vermont Department of Education BEST Initiative to plan and implement training and technical assistance activities for educators, mental health providers, family members and other people interested and involved in the system of care.

  Project staff have linkages with Trinity College's Master's and Certificate Program in Community Mental Health and with the University of Vermont's University Affiliated Programs of Vermont around preservice training needs as well as grant funded demonstration projects supporting children and families. They also collaborate with the colleges, universities, and State Departments of Education and of Social and Rehabilitation Services to plan and implement training and to produce an annual calendar of training and technical assistance offered throughout Vermont.

- ***A major focus of the Training and Technical Assistance Project is to support and promote the strengths and needs of local communities.***
  Project staff help to coordinate local trainings to meet the specific needs of communities. Peer Consultation and mentoring between individuals and organizations in Vermont is facilitated by project staff by "matching" local expertise from one area with local training needs in another area. A "menu" of individualized trainings is made available to local communities each year.

- ***The project's training conferences, although one-time events, have characteristics that have sustaining value to participants.***
  Training events offer opportunities for small group interactions between participants and trainers as opposed to lecture-only, expert-knows-best kinds of activities, and time for networking with peers from different parts of the state to share information and support. Some sort of celebration or acknowledgment of the good work done by providers is part of most training events. Resource

fairs of all the materials available as they relate to the conference topic is a popular feature of the project's training activities. The project seeks out Vermont practitioners who demonstrate exemplary practices to be presenters at training events, when possible, rather than bringing in "experts" from out-of-state.

Components of ACCESS Vermont's Training Approach

Eight components of *ACCESS Vermont*'s training approach are described below:

- ***Statewide Conferences***
  - Conferences of a general nature that bring large groups of people together to hear new information and have opportunities to network;
  - Everything You Always Wanted to Know about Education and the System of Care (regarding Children with Emotional/Behavioral Challenges) But Were Afraid to Ask;
  - The Wraparound Approach to Children's Services;
  - At the Crossroads: Finding Opportunities in Crisis;
- ***Specialized Training in Priority Areas or for Specific Groups as Needed***
  - Annual Vermont Children's Crisis Workers Training Conferences;
  - Annual Therapeutic Foster Care Training Conference for foster parents and program staff from mental health and child welfare foster care programs;
  - Statewide Training on Interagency Collaboration for therapeutic case managers and interested others; and
  - Statewide Training on Oppositional-Defiant Disorder for school-based mental health workers.
- ***Local or Regional Trainings.*** Single events as well as ongoing training and workshops are held at the regional or community level. Examples of these events include:
  - Teams and Teamwork;
  - Crisis Prevention and Intervention;
  - Eight-seminar Training Model for child care providers on creating quality environments for young children with disabilities;
  - Introduction to Wraparound Services; and
  - School Mental Health Workshops designed to offer strategies and networking opportunities for parents, educators, and school mental health clinicians focusing on keeping children in school.

- ***Affinity Groups.*** People working in similar service settings, but isolated in rural areas throughout Vermont, are organized into affinity groups. These groups meet four to six times a year for training, networking, peer support, peer supervision, and information-sharing on best practices. They also help design and run annual conferences. There are affinity groups for children's crisis outreach service managers and for therapeutic case managers.

- ***Parent Training Course.*** A 10-week, 30-hour parent training series is sponsored by the Vermont Federation of Families to train families to develop their advocacy skills to become regional family resource consultants. The course is offered regionally at locations around the state.

- ***Self-study Training Curricula.*** Three self-study training curricula are being developed. Each curriculum consists of videotapes and study guides designed to be used as self-study for clinicians or as independent training for individual practitioners and families. The guides include definitions, practical approaches, learning activities, and references. Topics are: Individualized Treatment Planning; Anger Management (skills-based approaches to challenging behaviors); and Oppositional-Defiant Behaviors (parent training curriculum on challenging behaviors).

- ***Video Series.*** Four 45-minute training videos with accompanying discussion guides are being produced for family members and interested service providers, by the Vermont Federation of Families. Video modules include:

  - Advocacy skills
  - Parent-professional partnership
  - Role of family members on interagency teams
  - Parents as Partners

- ***Local Technical Assistance.*** School districts and community teams are invited to work together to design local training plans and to develop local training and technical assistance activities. Families First and the Vermont BEST Planning Team coordinate a team of professionals who are available to provide technical assistance to local teams or to staff of particular agencies on such topics as conflict resolution and mediation, facilitation of planning efforts, and information about statewide initiatives and resources.

- ***A Training Calendar.*** The *ACCESS Vermont* Training and Technical Assistance Team and the Vermont BEST Initiative work collaboratively to produce a training calendar that lists workshops, conferences, and other Vermont training events related to children, adolescents and their families. The training events are offered by the Departments of Developmental and Mental Health Services, Education, and Social and Rehabilitation Services as well as the University of Vermont. Scholarships are available for family members of children and adolescents with emotional and behavioral challenges.

HAWAI'I 'OHANA PROJECT'S CASE MANAGEMENT CURRICULUM FOR COMMUNITY PROFESSIONALS

Contact for further information: Kate Pahinui (808) 674-0732

As described earlier, The Hawai'i 'Ohana Project's Case Management Curriculum was created in 1995 as a joint project between the Institute for Family Enrichment in Honolulu, the Wai'anae Coast Community Mental Health Center, Inc., and the Hawai'i 'Ohana Project—one of the Comprehensive Community Mental Health Services for Children and Their Families Program sites. The curriculum was designed to train 'community professionals' with diverse backgrounds to serve as effective case managers for children with emotional and/or behavioral difficulties and their families at the two sites of the Hawai'i 'Ohana Project. Community professionals are community members who may lack formal postsecondary education yet who have a wealth of knowledge and skills gained through personal experience as caregivers of children with emotional and behavioral difficulties and as people who are active in the community, and understand the local culture.

The curriculum was based on the Wai'anae model of case management. The Hawai'i 'Ohana Project adapted and refined some of the activities and materials from the Multiagency Case Management Curriculum developed in North Carolina through a partnership between the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the University of North Carolina-Chapel Hill, School of Social Work.

The curriculum is guided by three key premises:

- The family is a system, so services and supports must impact the whole family, not just the child.
- Learning occurs on two levels, the cognitive (knowledge) and the affective (feeling), so education must engage participants on both levels in order to be effective.
- Individuals who feel good about themselves and have confidence in their abilities are more effective case managers.

The curriculum consists of three units of learning:

- Case Management Values and Attitudes
- Partnerships with Children and Families
- Case Management

The first two units provide background for people who are new to the field and to the target population. The third unit presents the nuts and bolts of case management. Each of the three units consists of a number of modules. Many examples from experiences in Hawai'i are used to illustrate key points. The examples may be used as starting points for discussing cultural issues in mainland communities interested in adapting the curriculum for their own purposes.

The training comprises 40 hours delivered over a 3- to 5-day time period. People who attend the full training receive a certificate of completion. Others receive a certificate of attendance. Over 200 community professionals have been trained.

The Hawai'i Department of Health's Child and Adolescent Mental Health Division has given legitimacy to the training by including the provision of care coordination and case management services by community professionals in its Clinical Standards Manual as long as staff are credentialed through training using this curriculum. The same agreement has been negotiated with health maintenance and behavioral health organizations in the state.

FRIENDS OF THE FAMILY CAPACITY-BUILDING EDUCATION PROGRAM
HOUSTON, TEXAS
Contact for further information contact: Nelda Lewis (713) 659-8630 ext. 115.

"People in Partnership" was formed as a nonprofit organization in 1996 to continue the work of The Annie E. Casey Foundation's Mental Health Initiative for Urban Initiative in a neighborhood in Houston. The Partnership's vision is:

- to holistically support and facilitate the self-empowerment of families;
- to utilize the knowledge and strengths of families, neighborhood, community, city, county, state, and nation; and
- to develop a quality, family-centered health and human services support system which promotes the mental health and well-being of children and other stakeholders in Houston's Third Ward neighborhood and throughout Texas.

One component of their work has been the development of the *Friends of the Family Capacity-Building Education Program,* a curriculum developed to train families, neighborhood residents, service providers, volunteers, agency staff, community service providers, and others interested in enhancing their skills and knowledge of the helping process.

The program is provided in partnership with the Texas Southern University's Social Work Program. In addition to the University providing classroom space and administrative supports, faculty members provide some of the training. Participants who complete 60 hours of training receive certification of completion and designation as a "Friend of the Family," which allows them to become a member of the People in Partnership provider network as family support workers. Although at present these positions are unfunded, the intention is for them to be established as paid positions. People in Partnership is working towards a certification that will lead to graduates being eligible as providers for reimbursement through Medicaid or private insurers. The Partnership would also like to have the course recognized as a legitimate training activity for people on the state's welfare-to-work program.

The complete curriculum consists of 13 sessions (60 hours) of class work, an internship, and graduation activities. The overall content and format include: discussion and exposure to exploration of personal values and values of those being served; obtaining a knowledge base as the foundation for working with and on behalf of families; development of skills that facilitate effective intervention; and participation in a directed experience which reflects the work and philosophy of People in Partnership. The thirteen sessions cover the following content units:

- Principles of Family Support/Practice;
- Human Growth, Behavior and the Social Environment;
- Personal Development;
- Assessment Techniques and Intervention;
- Ethical Practice Principles; and
- Specialized Skill Development (which includes First Aid/CPR, Behavior Management, Crisis Identification and Intervention, honoring diversity).

Each unit represents a principle or value of Nguza Saba (Swahili translation for Seven Principles). In addition, four hours of practical application (internship) must be completed to receive a certificate of completion. Most sessions are held on Saturdays from 10:00 a.m. to 2:00 p.m. Two sessions are from 9:00 a.m. to 4:00 p.m. Child care is provided if needed, for a small donation. There is a registration fee of $10.00. The costs for operating the program are estimated to be about $10,000 to cover the facilitator, child care, food, and staff and administrative expenses. A participant may either pay $250 to take the course, or provide 40 hours of volunteer services in a community agency, through People in Partnership's Time Honored Exchange Time Dollar program. There are no prerequisites for taking the course. The course was first offered in the Fall of 1997 with 11 graduates. Six more will complete the spring 1998 course. It will continue to be offered twice each year.

ADVICE FROM THE FIELD

In gathering information about promising practices for training strategies from the perspective of different states and communities, we interviewed those responsible for training in several of the comprehensive service sites. When asked what advice they would give others, they offered the following suggestions, presented in Exhibit 8.

Exhibit 8

SOME ADVICE FROM THE FIELD

- Learning is lifelong. It is not finished at any one point in time, where you can say "I'm done." One is never done.
- Effective training has to be incorporated into all you do.
- Training is anything that helps people do their jobs better. Training is not separate from everything else you do.
- Target training in response to needs. Adult learners know what they need. Their input is very important. Give them the information they ask for. Tell them what they want to know, not what you want to tell them.
- If there is a need for information, get the information out. You don't always have to spend a lot of time and money to develop a fancy curriculum to be responsive to needs from the field. It's a myth that if it's not glitzy it's not training.
- The hours you put in before the training—finding out about your constituency, what they need to hear, what they are bracing themselves for, what they fear and distrust—is the key to whether the training will be successful.
- We do not live in a training-friendly environment. Under managed care, people feel the pressure for billable hours. They do not have time for training. It is not structured into their jobs. Therefore, try and fit into people's lives as much as possible. Find a natural time in their day, week, or month. Go to meetings already on their schedules rather than adding to already burdened schedules.
- Partner with existing training organizations and networks, such as Area Health Education Centers.
- One shot trainings or sending one person from a community to a training "somewhere else" are not useful strategies. They don't allow for relationship building. Use training opportunities strategically by sending teams with learning goals and objectives and a plan to share the learning when they return home. Such experiences help strengthen relationships among team members, which helps with mutual support and collaboration back home.
- The process is as important, if not more important, than the content of the training. Relationship building and networking are key vehicles for training. People learn much from each other. Therefore, part of training is to create opportunities for linking with and learning about work in other communities.
- Build in ongoing agency support for applying practices and principles from training by training administrators, supervisors, and those who participate in agency staffings.
- It is important that training address how to handle the inevitable tensions that arise as principles and practices are implemented, representatives from various agencies and systems work together, and people assume new roles.
- Model the collaborative system of care principles in training by using training teams that include parents, providers, service coordinators and others. This gives people a sense that collaboration actually works.

Chapter VII
Where to Go from Here

As the material in the prior chapters demonstrate, developing an approach to training that supports the development of people qualified and competent to work in systems of care—to design, administer, deliver, research, and evaluate such systems at the state and local levels—is a complex process that requires the involvement of many stakeholders over a period of time. The implications of what has been presented point to the necessity for a transformation in both preservice and inservice training from the traditional approaches still very much in place. There is a need for all those involved in training to develop a clear understanding of the necessary competencies based on a set of broad principles and knowledge both of what works to improve outcomes, and what appear to be promising practices even though not yet supported by empirical findings. There also is a need to develop training systems that incorporate effective training methods and assure that those in practice are competent in using the knowledge, skills, values and attitudes they possess.

This chapter provides an approach to thinking about this process in an evolutionary framework, and outlines the steps each of the major groups might consider in working toward developing a system of training that reflects the most advanced thinking as discussed in this monograph.

A TRAINING CONTINUUM

Exhibit 9 presents a way of thinking about a developmental continuum of approaches to training, from the more traditional approaches that are still the most typical, to a unified approach that is integrated across systems and involves the full range of stakeholders, including families, communities, and colleges and universities. These may be considered stages in an evolutionary process, which we have labeled *traditional*, *modified*, *integrated*, and *unified*.

Traditional

In the traditional approach to training, training is developed and delivered along categorical boundaries, both by discipline and by system. Preservice training is separate and apart from what is happening in the field and does not incorporate the principles and practices of a system of care approach, either in the content taught or the process of teaching. People in the field receive training largely through attending one shot workshops or conferences, usually on an individual rather than team basis. There is no involvement of families or consumers in any aspect of the planning, implementation, or evaluation of training.

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Exhibit 9
A Developmental Training Continuum
Characteristics of Partnerships Between State Agencies, Institutions of Higher Learning, Families & Communities and Their Impact upon Practice

	Traditional	Modified	Integrated	Unified
System	• State systems/departments develop policy, professional training along specialty guild lines. • Systems promote development, strengthening of specialty focus.	• State systems/departments independently adopt similar philosophy, often promoting collaboration, but continue training and policy with specialty focus.	• State systems/departments begin sharing training calendars, coordinate schedules to avoid overlap - circulate across department boundaries. • Funding streams are shared, promotion of cross-training begins.	• State systems/departments begin pooling training staff, merging training events through common purpose, sharing costs/benefits.
Program	• Community agencies & institutions of higher ed. operate in isolation. • Disciplines train in isolation from one another and independent of field practice. • Instruction is often didactic, using "expert model". • No agency administrative support for transfer of training to improve practice.	• Community agencies & institutions of higher learning begin joint efforts around research and evaluation. • Preservice training remains separate from field.	• Community agencies and institutions of higher ed. begin to collaborate through integration of field staff/families into preservice training. • Student field placements cross agency boundaries. • Cross agency training gains support.	• Community agencies and institutions of higher ed. begin to collaborate with larger community. • Families and field staff review/input into training curriculum, are co-instructors in preservice. • Curricula reflecting current practices and goals are merged into curricula. • Training is targeted to prepare new professionals for collaborative work, new models for clinical fidelity in cross-agency teams emerging.
Practice	• Participation in professional conferences/workshops, on individual basis within agency boundaries. • Services are provided within agency boundaries.	• Staff receive training which promotes collaboration, with similar philosophies, but receive it within agency boundaries. • Specialty focus predominant. • Services remain within agency boundaries.	• Service teaming is promoted through cross-agency training which emphasizes similarities in mission/population; need to reduce duplication.	• Service teams with full family inclusion are the norm. • Redefined specialty practice roles develop to support professional identity while promoting collaboration.

Modified

As boundaries between systems begin to loosen, and collaboration is promoted, the content of training begins to incorporate some of the newer principles and practices of an integrated, system of care model. The training, however, is still done within boundaries of specialties or categorical service systems. Universities and community agencies begin to work together on research and evaluation projects, but preservice training is still fairly traditional.

Integrated

At a higher level of development, boundaries dissolve even further. State systems begin coordinating their training efforts, sharing information, and coordinating schedules. The promotion of cross-training begins to emerge. University-based preservice training programs begin to involve families and field staff in the training they offer and students have opportunities for placements in community agencies. Staff from multiple systems or agencies in the field attend trainings in teams, recognizing the common populations they serve.

Unified

In an ideal system, training resources and efforts are pooled across child-serving systems with common funding, staffing, and events. Institutions of higher education, community agencies, and family representatives work closely to develop training at both the preservice and inservice level, to be responsive to the needs of the field. Curricula reflect current practices and goals. Inservice training goes far beyond one-shot workshops and conferences to reflect a systemic approach, with ongoing administrative and supervisory support to assure transfer of training and change in practice.

What Can Be Done?

As state or local systems look to reform the way they conceptualize, organize, deliver, and evaluate their training, in order to move from a traditional approach to an integrated, and ultimately unified systemic approach to training people at both the preservice and inservice levels to work in systems of care for children and families, there is much that each of the major participant groups involved might do. Based on the literature presented in this document and the experiences of innovators in the field described throughout, some recommendations are offered for consideration by institutions of higher education, community agencies, state and federal government administrators and policy makers, family organizations, and professional organizations and professional accrediting boards (Kravitz, 1991; Behar, 1993; Friedman, 1993).

Universities and Colleges

- ***Change Curriculum.***
  - Review and modify course work and practical experience to assure relevancy for current practice. Integrate systems of care concepts and skills into coursework.
  - Add relevant new courses.
  - Develop innovative, state-of-the-art practicum and internship experiences in community-based service sites
  - Include family members, policy makers, and agency staff in formulating, delivering, and evaluating curricula.
  - Have family members and family advocates review curriculum and teaching resources (readings, videos) for relevancy and accuracy.
  - Provide training in evaluation and research techniques to encourage participatory methods for testing the effectiveness of systems of care.

- ***Assure faculty competence.***
  - Help faculty to be aware of the philosophy, goals, and practices of systems of care approaches for children and families.
  - Support faculty to acquire the recommended skills, knowledge and professional socialization within their own discipline, as well as acquire knowledge and skills across professions to design, deliver, and manage new services and service systems and conduct field-based research and evaluation.
  - Increase faculty access to system of care content through faculty development institutes, attendance at relevant conferences and workshops, and organizing a variety of ways for them to have contact and involvement with the field. Provide resources and incentives for faculty to participate.
  - Recruit faculty with specific expertise in systems of care.
  - Reward current faculty who update their practice and teaching skills in work with families and children at risk.

- ***Promote cross-disciplinary/integrated practice.***
  - Build better bridges among disciplines so practitioners can reinforce and support each other across disciplines in meeting the needs of children and families.
  - Run joint practicum seminars across disciplines.

- ***Collaborate with state and community agencies and families.***
  - Develop and maintain close relationships between universities, state and local public and nonprofit agencies, and families to collaborate on practice issues.
  - Bring in quality agency staff and family members to teach courses, serve on committees, give guest lectures.
  - Have faculty consult with agencies on research and evaluation or in case conferences.
- ***Promote relevant scholarship.***
  - Encourage more research in areas related to effective practice with families and children, especially innovative field research.
  - Identify and support opportunities for faculty to produce products or reports on practice in ways that will be recognized and rewarded within their university's criteria for advancement.
  - Involve family members, policy makers, and agency staff in formulating, delivering, and evaluating research.

Community Agencies

- ***Develop a systemic approach to training for all staff.***
  - Develop a sound staff development and training program that is reinforced by administrative policies and effective supervision that allow for transfer of training to the workplace setting.
  - Incorporate relevant competencies into staff performance expectations.
  - Involve key stakeholders in systems of care in planning and developing training approaches.
- ***Collaborate with institutions of higher education.***
  - Serve as learning laboratories with key staff designated and supported as faculty to demonstrate effective practice and work one-to-one with interns and visiting observers.
  - Forge new relationships between their programs and the universities.
  - Provide opportunities for faculty practice time.
  - Support faculty research on public sector practice.
- ***Partner with family organizations.***
  - Include families in the design and delivery of training, both as trainers and trainees.

- Provide financial supports and incentives for families to participate in training, both as trainers and trainees.

Federal and State Government Administrators and Policy Makers

- ***Develop and disseminate relevant information about training needs and opportunities.***

- ***Provide financial support and incentives.***

  - Provide fiscal incentives to help develop practicum and internship opportunities in systems of care and explore funding through federal and state funding streams.

  - Fund clinical and research training programs to support and sustain the work of the comprehensive service system grant program.

  - Incorporate nationally recognized standards for competent practice and service delivery into funding criteria.

  - Base funding decisions for training on the application of strategies that have been demonstrated to be effective.

- ***Collaborate with institutions of higher education.***

  - Collaborate with university faculty in the design and delivery of relevant inservice and preservice training curricula.

  - Explore opportunities to create more formal public-academic liaison programs or establish university-based state training and technical assistance centers, such as the Pennsylvania Child and Adolescent Service System Program Institute at Pennsylvania State University.

- ***Reform licensing and credentialing standards.***

  - Review and modify state certification standards for professionals to incorporate a collaborative, family-centered, community-based approach to service delivery.

  - Create state-based certification criteria and programs for those without higher education credentials (e.g., community professionals' family support workers).

  - Require topic specific continuing education training consistent with identified competencies and values for retention of professional licensure.

Family Organizations

- ***Form partnerships with institutions of higher education and community agencies that sponsor and provide inservice training.***

  - Become involved in teaching in preservice training programs in colleges and universities.

- Find ways to become involved in teaching in inservice training programs.
- Volunteer to serve on agency committees to help plan and design staff development programs.
- Participate in developing training curricula material at all levels.
- Serve as coaches and mentors to help staff work effectively with families.

- ***Advocate for changes/reforms in state level policies around training, service delivery, and professional licensing/certification.***

- ***Enroll in training programs and courses to enhance skills that will enable assuming multiple roles in the system of care including provider, evaluator, administrator, and board member, among others.***

Professional Organizations and Accreditation Boards

- ***Review and update accreditation guidelines to assure inclusion of training for competencies relevant to the field of practice.***

- ***Involve broader constituencies such as consumers and family members and public sector administrators and policy makers.***

- ***Offer organization sponsored continuing education and skill-based training on relevant competencies.***

References

American Academy of Child and Adolescent Psychiatry. 1996. *Guidelines for training towards community-based systems of care for children with serious emotional disturbances*. Washington, D.C.: American Academy of Child and Adolescent Psychiatry.

American Mental Health Counselors Association. 1993. *National standards for the clinical mental health counseling*. Revised ed. Alexandria, VA: American Mental Health Counselors Association.

Behar, L. 1993. Public-academic collaboration in training child mental health professionals. Chapter 9 in *Serving the Seriously Mentally Ill: Public-Academic Linkages in Services, Research, and Training*, edited by P. Wohlford, H. Myers, and J. Callan. Washington, D.C.: American Psychological Association. 185-194.

Bickman, L., W. Summerfelt, and M. Foster. 1996. Research on systems of care: Implications of the Fort Bragg evaluation. Chapter 18 in *Children's mental health: Creating systems of care in a changing society*, edited by B. Stroul (Baltimore: Paul H. Brookes).

Brandon, R. and L. Meuter. 1995. *Proceedings: National Conference on Interprofessional Education and Training*. Seattle: Human Services Policy Center, University of Washington.

Cantor, J. 1992. *Delivering Instruction to Adult Learners*. Toronto: Wall & Emerson.

Capra, F. 1996. *The Web of Life*. NY: Anchor Books.

Cognitive Design Associates. 1998a. "Implications for adult learning and instructional design based upon the work of Malcolm Knowles." [On-line]. Available: www.acquireskills.com/impinsds.htm

Cognitive Design Associates. 1998b. "Andragogy...a highly relevant adult learning theory." [On-line]. Available: www.acquireskills.com/andragog.htm

Cornell Empowerment Group. 1989. Empowerment through family support. In *Networking Bulletin 1*, p. 7. of *Empowerment and family support*, edited by M. Cochran (Ithaca, NY: Cornell Cooperative Extension. ph: 607-255-1820).

Cranton, P. 1992. *Working with Adult Learners*. Toronto: Wall & Emerson.

Cross, T., B. Bazron, K. Dennis, and M. Isaacs. 1989. *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. vol. I. Washington, D.C.: CASSP Technical Assistance Center, Georgetown University Child Development Center. 202-687-5000.

Curry, D. 1997. Factors affecting the perceived transfer of learning of child protection social workers. Ph.D. diss., Kent State University Graduate School of Education.

Curry, D., P. Caplan, and J. Knuppel. 1994. Transfer of training and adult learning (TOTAL). *Journal of Continuing Social Work Education* 6:8-14.

Fecser, F. 1994. *Building systems of care: The training component.*. Paper presented at the meeting of the National Resource Network for Child and Family Mental Health Services, Washington, D.C. Available from Positive Education Program, Cleveland, OH. 216-361-4400.

Friedman, R. 1993. Preparation of students to work with children and families: Is it meeting the need? *Administration and Policy in Mental Health* 20:297-310.

Friesen, B. 1989. Child mental health training in schools of social work: A national survey. In *Social work education for working with seriously emotionally disturbed children and adults*. (pp. 26-38). National Association of Deans and Directors of Schools of Social Work.

Gardner, S., J. George, M. Gil de Gibaja, M. Jordan-Marsh, J. Lind, J. McCroskey, H. Taylor, S. Taylor-Dinwiddle, J. Zlotnik. 1997. A working paper on interprofessional education principles. Working paper, Alexandria, VA: Council on Social Work Education.

Gallagher, P., D. Malone, M. Cleghorne, and K. Helms. 1997. Perceived inservice training needs for early intervention personnel. *Exceptional Children*. 64:19-30.

Goldman, S. and M. Irvine. 1997. *Report of the Child and Adolescent Panel for the Mental Health Managed Care and Workforce Training Project*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center. 202-687-5000.

Goldstein, I. 1993. *Training in organizations*. 3rd ed. Pacific Grove, CA: Brooks/Cole.

Handron, D., D. Dosser, Jr., S. McCammon, and J. Powell. 1998. "Wraparound" -- the wave of the future: Theoretical and professional practice implications for children and families with complex needs. *Journal of Family Nursing*. 4:65-86.

Hanley, J. 1994. Use of bachelor-level psychology majors in the provision of mental health services to children, adolescents, and their families. *Journal of Clinical Child Psychology*. 23 (suppl.):55-58.

Hansen, M., C. Anderson, C. Gray, S. Harbaugh, M. Lindblan-Goldber, and D. Marsh. 1996. *Child, family and community core competencies*. Rev. ed. Harrisburg, PA: Pennsylvania Child and Adolescent Service System Program Training and Technical Assistance Institute.

Henggeler, S., L. Rone, C. Thomas, and J. Timmons-Mitchell. 1998. *Blueprints for Violence Prevention: Multisystemic Therapy*. In series edited by D.S. Elliott. University of Colorado, Center for the Study and Prevention of Violence. Boulder, CO: Blueprints Publications.

Henggeler, S., M. Brondino, G. Melton, and D. Scherer. 1997. Multisystemic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology*. 65:821-833.

Hooper-Briar, K. and H. Lawson. 1994. *Serving children, youth and families through interprofessional collaboration and services integration: A framework for action*. Oxford, OH: The Danforth Foundation and the Institute for Educational Renewal, Miami University.

Isaacs, M. & Benjamin, M. 1991. *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed. Programs which utilize culturally competent principles.* vol. II. Washington, D.C.: CASSP Technical Assistance Center, Georgetown University Child Development Center. 202-687-5000.

Jivanjee, P., K. Moore, K. Schultze, and B. Friesen. 1995. *Interprofessional education for family-centered services: A survey of interprofessional/interdisciplinary training programs.* Portland, OR: Research and Training Center on Family Support and Children's Mental Health, Portland State University. 800-628-1696.

Johnson, H. (editor). 1993. Child mental health in the 1990s: curricula for graduate and undergraduate professional education. Rockville, MD: U.S. Department of Health and Human Services, Center for Mental Health Services.

Kinney, J., K. Strand, M. Hagerup, and C. Bruner. 1994. *Beyond the Buzzwords: Key principles in effective frontline practice.* Falls Church, VA: National Center for Service Integration. 703-824-7447.

Knapp, M., K. Barnard, R. Brandon, N. Gehrke, A. Smith, and E. Teather. 1993. University-based preparation for collaborative interprofessional practice. In The politics of linking schools and social services: The 1993 politics of education association yearbook (theme issue), edited by L. Adler and S. Gardner. *Journal of Education Policy,* 8:137-151.

Knowles, M. 1984. *Andragogy in Action.* San Francisco: Jossey-Bass.

Kravitz, S. (1991). Professional social work education and public child welfare. In *Assets and the poor: A new American welfare policy,* edited by M. Sherraden and N. Gilbert: Armonk, NY: M. E. Sharpe, Inc., 29-36.

Lane, C. and S. Cassidy. 1994. The role of technology in the systemic reform of education and training Part 11. [On-line] Available: www.wested.org/tie/dlrn/reformtechpart11.

Magrab, P. and P. Wohlford, P., editors. 1990. *Improving psychological services for children and adolescents with severe mental disorders: Clinical training in psychology.* Washington, D.C.: American Psychological Association.

Mazer, N. 1996. Santa Barbara County Multiagency Integrated System of Care: Training concept paper. Unpublished. Santa Barbara: Author

National Association of School Psychologists. 1997. Standards for the credentialing of school psychologists - Revised. Bethesda, MD: National Association of School Psychologists. 301-657-0270.

National Peer Technical Assistance Network. In Press. *Family-Professional relationships: Moving forward together.* Available from Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center. 202-687-5000.

National Staff Development and Training Association (NSDTA). 1993. *A key to success: Guidelines for effective staff development & training programs in human service agencies.* Buffalo, NY: American Public Welfare Association (APWA)/NSDTA.

—. 1997. *Instructor Competency Model.* Buffalo, NY: APWA/NSDTA.

Osher, T., Toth-Dennis, D., deFur, E., Nava, C. and Spencer, S. In press. *New roles for families in systems of care.* Rockville: Center for Mental Health Services.

Pires, S. 1996. Human resource development. Chapter 15 in *Children's mental health: Creating systems of care in a changing society*, edited by B. Stroul (Baltimore: Paul H. Brookes).

—. 1996. *Lessons learned from the Fort Bragg Demonstration: An Overview.* Washington, DC: Human Services Collaborative. 202-333-1982.

Powell, J., D. Dosser, Jr., D. Handron, S. McCammon, M. Evans, and M. Kaufman. In press. Challenges of interdisciplinary collaboration: A faculty consortium's initial attempts to model collaborative practice. *Journal of Family Practice.*

Reich, J. 1998. Do we know what students are getting from their education? *American Psychological Association Monitor*, June, 1998, 41.

Roberts, M., C. Carlson, M. Erickson, R. Friedman, A. LaGreca, L. Lemanek, S. Russ, C. Schroeder, L. Vargas, and P. Wohlford. 1998. A model for training psychologists to provide services for children and adolescents. *Professional Psychology: Research and Practice.* 29:293-299.

Roberts, M., P. Magrab. 1991. Psychologists' role in a family-centered approach to practice, training, and research with young children. *American Psychologist*, 46:144-148.

Robertson, R. 1997. Walking the talk: Organizational modeling and commitment to youth and staff development. *Child Welfare.* 76:577-589.

Salas, E., and J. Cannon-Bowers. 1997. Methods, tools, and strategies for team training. Chapter 10 in *Training for a rapidly changing workplace: Applications of psychological research,* edited by M. Quinones and A. Ehrenstein. Washington, D.C.: American Psychological Association.

Schoenberg, S. 1995. *Making it happen: A guide to program development for services to children and adolescents who are experiencing a severe emotional disturbance and their families.* Washington, D.C.: National Resource Network for Children and Family Mental Health Services at the Washington Business Group on Health.

Schorr, L. 1997. *Common Purpose: Strengthening Families and Neighborhoods to Rebuild America.* NY: : Anchor Books.

Sechrest, L. and A. Scott. 1993. Assessing the Competencies of Clinical Psychologists. In *Serving the Seriously Mentally Ill: Public-Academic Linkages in Services, Research, and Training,* edited by P. Wohlford, H. Myers, and J. Callan. Washington, D.C.: American Psychological Association. 185-194.

Senge, P. 1994. *The Fifth Discipline*. NY: Currency/Doubleday.

Sexton, D., P. Snyder, B. Wolfe, and M. Lobman. 1996. Early intervention inservice training strategies: Perceptions and suggestions from the field. *Exceptional Children*. 62:485-492.

Short, R. 1997. Education and training for integrated practice: Assumptions, components, and issues. Chapter 15 in *Integrated services for children and families: Opportunities for psychological practice*. Washington, DC: American Psychological Association.

Simpson, J., N. Koroloff, B. Friesen, and J. Gac. In press. Promising practices in family-provider collaboration. Rockville, MD: Center for Mental Health Services.

Smith, E., J. Ford, and S. Kozlowski. 1997. Building adaptive expertise: Implications for training design strategies. Chapter 4 in *Training for a rapidly changing workplace: Applications of psychological research*, edited by M. Quinones and A. Ehrenstein. Washington, DC: American Psychological Association.

Smith, A. and B. Hutchison. 1992. *An analysis of human service practitioner competencies necessary for effective interprofessional collaboration*. Seattle, WA: Human Services Policy Center, University of Washington.

Stroul, B. and R. Friedman. 1994. *A system of care for children and youth with severe emotional disturbances*. revised ed. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Vander Ven, K. 1986. "And you have a ways to go": The current status and emerging issues in training and education for child care practice. In *Competent caregivers -- Competent children: Training and education for child care practice*, edited by K. Vander Ven and E. Tittrich. New York: Haworth Press.

Vander Ven, K. 1993. Advancing child and youth care: A model for integrating theory and practice through connecting education, training, and the service system. *Child and Youth Care Forum*. 22:263-283.

Walizer, E. and P. Tanner Leff, P. 1993. Personal narratives and the process of educating for the healing partnership. *Zero to Three*, 14:21-25.

Zlotnik, J. 1997a. *Preparing the workforce for family-centered practice: Social work education and public human services partnerships*. Alexandria, VA: Council on Social Work Education.

Zlotnik, J. 1997b. *Promoting public sector practice for psychologists: Are there lessons to be learned from social work*. A working paper prepared for American Psychological Association work group on innovative training. Alexandria, VA: Council on Social Work Education.

APPENDICES

Appendix A

MEMBERS OF THE WORK GROUP WHO ASSISTED IN PREPARING THIS DOCUMENT

Jane Adams, Ph.D., Executive Director, Keys for Networking, Inc.

Marva Benjamin, A.C.S.W., Director of Cultural Competence Initiative, National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center

Charles Biss, M.S.W., Department of Developmental and Mental Health Services, State of Vermont

Richard Brandon, Ph.D., Human Services Policy Center, University of Washington

John Burchard, Ph.D., University of Vermont

Robert Friedman, Ph.D., Professor & Chair, Research & Training Center for Children's Mental Health, Florida Mental Health Institute

Barbara J. Friesen, Ph.D., Director, Research & Training Center on Family Support & Children's Mental Health, Portland State University

Jerome Hanley, Ph.D., Division of Children, Adolescents, & Their Families, Department of Mental Health, State of South Carolina

Marsali Hansen, Ph.D., Director, Pennsylvania CASSP Training & Technical Assistance Institute

Scott Henggeler, Ph.D., Medical University of South Carolina, Department of Psychiatry and Behavioral Science

Larke Nahme Huang, Ph.D., Senior Policy Associate, National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center

Marisa de la Cruz Irvine, M.P.P., Policy Associate, National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center

Martha Kaufman, M.A., Community Mental Health Consultant, North Carolina Department of Mental Health, Developmental Disabilities, & Substance Abuse Services, Child & Family Services Branch

Jane Knitzer, Ed.D., Deputy Director, National Center for Children in Poverty, Columbia University School of Public Health

Susan McCammon, Ph.D., Department of Psychology, East Carolina University

Neal Mazer, M.D., M.P.H. System of Care Development Specialist, Santa Barbara County, Multiagency Integrated System of Care

Sherry Schoenberg, M.A. Project Coordinator, Families First, Vermont.

Sandra Spencer, B.A., Executive Director, WE CARE Family Advocacy and Support Organization

Nancy Winters, M.D., Assistant Professor, Child & Adolescent Psychiatry, Oregon Health Sciences University

Harry Wright, M.D., M.B.A., Professor, William S. Hall Psychiatric Institute, University of South Carolina
Joan Levy Zlotnik, Ph.D., A.C.S.W., Director of Special Projects, Council on Social Work Education

In addition, staff at Georgetown provided editing of the final draft - Joan Dodge, Ph.D., Senior Policy Associate and Amy Wischmann, M.A., Policy Associate

The following individuals assisted with the review and editing of Chapter 4, on the North Carolina PEN PAL Project.

Lenore Behar, Ph.D., North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NC DMH/DD/SAS), Child and Family Services Section
Section Chief, Principal Investigator for PEN-PAL and NC FACES Projects
Mark O'Donnell, M.P.H., NC DMH/DD/SAS, Child and Family Services Section
Research Director, PEN-PAL and NC FACES Projects
Carol MacKinnon-Lewis, Ph. D., University of North Carolina in Greensboro
Director, Center for the Study of Social Issues
Susan McCammon, Ph. D., East Carolina University, Department of Psychology
Chair, Social Sciences Training Consortium
Laura Weber, M.A., University of North Carolina in Greensboro and NC DMH/DD/SAS, Child and Family Services Section, Statewide Public-Academic-Liaison Coordinator, PEN-PAL and NC FACES Projects
Sandra Spencer, B.A., PEN-PAL Project
Executive Director, WE CARE Family Advocacy and Support Organization
Irene Zipper, Ph. D., University of North Carolina, Chapel Hill, School of Social Work
Director, Child Mental Health Project

Appendix B

WORKFORCE COMPETENCIES FOR DIRECT SERVICE STAFF SERVING CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL & BEHAVIORAL PROBLEMS, AND THEIR FAMILIES

Santa Barbara Training Priorities

I. DEMONSTRATES RESPECT FOR CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL AND BEHAVIORAL PROBLEMS.

A. Uses language and behavior which consistently reflects and perpetuates the dignity of children and youth with serious emotional and behavioral problems.

1. Written materials
2. Verbal communications

B. Demonstrates a holistic understanding of children and youth with serious emotional and behavioral problems, and their families.

1. Stages and milestones in basic child, adolescent, and adult development
2. Basic needs for food, shelter, clothing, affiliation, and dignity
3. Individual strengths, interests, and capabilities
4. Impact of serious emotional disturbance on self and on family expectations

C. Involves child or youth in all aspects of service planning and support activities.

1. Invites and fosters expression of child/youth goals and preferences
2. Assists child/youth and family in reaching mutually agreeable goals
3. Provides support and resources as needed to facilitate involvement of child/youth

D. Provides relevant information as needed.

1. Provides information about serious emotional and behavioral problems, medications, services and resources
2. Provides information about target symptoms, possible side effects, anticipated problems, other contingencies
3. Provides referrals to appropriate resources as needed

II. DEMONSTRATES RESPECT FOR FAMILY MEMBERS OF CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL AND BEHAVIORAL PROBLEMS

A. Communicates understanding of unique issues facing family members.

1. Recognizes family experience, knowledge, and strengths
2. Demonstrates sensitivity to family concerns and needs
3. Identifies the impact of serious emotional and behavioral problems in youth on family relationships and dynamics

B. Demonstrates knowledge of family support resources.

1. Within neighborhood and local community
2. Statewide and national activities

C. Solicits family input and collaboration in service planning and support activities.

1. Invites and fosters expression of information, personal concerns and needs utilizing outreach when necessary to support family involvement
2. Provides support and resources as needed to facilitate involvement
3. Includes family members as members of treatment team

III. DEMONSTRATES KNOWLEDGE ABOUT SERIOUS EMOTIONAL AND BEHAVIORAL PROBLEMS AND THEIR IMPACT ON CHILDREN, YOUTH, AND THEIR FAMILIES.

A. Demonstrates knowledge about the differential characteristics and courses of serious emotional and behavioral problems.

1. Demonstrates knowledge about diagnosis, duration, and disability
2. Demonstrates knowledge about various theories about the causation and etiology
3. Recognizes the unique needs of children and youth with serious emotional and behavioral problems and co-occurring disorders of substance abuse, learning disabilities, developmental disabilities, physical disabilities, personality disorders, traumatic brain injury.

B. Demonstrates understanding of the effects of stressful life events on children/youth and families.

1. Recognizes the dynamics of sexual abuse and abusive relationships
2. Recognizes the impact of exposure to family violence
3. Recognizes the impact of loss (e.g. death, divorce, multiple foster placements) on children/youth and their families
4. Recognizes the impact of out-of-home placements on children/youth and their families
5. Recognizes the impact of chronic learning problems and school failure

6. Identifies the impact of inadequate housing and homelessness
7. Recognizes the unique needs of adolescents with serious emotional and behavioral problems who are also parents
8. Recognizes the impact of having parents with chronic mental illness

C. Demonstrates knowledge concerning the impact of stigma of serious emotional and behavioral problems or mental illness on children, youth, and families

1. Demonstrates sensitivity and understanding regarding name-calling
2. Understands differences in various classroom & educational settings & the relevance in peer culture
3. Able to collaborate effectively with parents, youth, and advocates

D. Demonstrates knowledge about psychotropic medications

1. Identifies the primary psychotropic medications used in the treatment of children/youth with serious emotional and behavioral disturbances, and their actions and side effects
2. Provides accurate and timely information about the benefits and side effects of medications
3. Identifies high-risk drug interactions and appropriate intervention strategies
4. Recognizes and responds to high-risk side effects
5. Recognizes and responds to basic medical problems

IV. DEMONSTRATES UNDERSTANDING OF PRINCIPLES OF COLLABORATIVE, COMMUNITY BASED CARE.

A. Operationalizes the principles of unconditional care.

1. Recognizes that no child is denied access to services, refused help, or ejected from the system because of the severity of his/her problem
2. Demonstrates that all services are inclusionary

B. Operationalizes the principles of child and family-centered services.

1. Includes family and community members in treatment team
2. Provides services in the least restrictive, most facilitative environment
3. Assures that services are culturally appropriate, and that providers are culturally competent and respectful
4. Supports the "best fit" of services and supports
5. Understands and implements strengths-based approach in working with child and family

C. Operationalizes the principles of community-based care.

1. Identifies the differences in assumptions and interventions between medical, residential and community-based services
2. Recognizes the value of providing a combination of concrete therapeutic, rehabilitative, and educational services
3. Identifies the value of delivering services in context of a treatment team
4. Provides individualized services that emphasize the development of competence in social, thinking and living skills
5. Utilizes natural support systems

D. Operationalizes the principles of cultural competence

1. Understands and respects different philosophies, lifestyles, and value systems
2. Demonstrates ability to communicate when there are perceived language, cultural, gender, or socioeconomic barriers
3. Demonstrates knowledge and skills related to minimizing cultural/racial/gender biases in diagnosis, the evaluation of the level of functioning, and/or in treatment
4. Understands cultural issues associated with access to care, service utilization, and the understanding and expression of problems or illness
5. Understands the role of religions beliefs and institutions in the lives of children and families
6. Demonstrates ability to utilize cultural, ethnic, and religious natural support systems as part of an effective treatment plan

V. DEMONSTRATES KNOWLEDGE OF A VARIETY OF APPROACHES TO INTERVENTION AND SUPPORT FOR CHILDREN/YOUTH AND THEIR FAMILIES.

A. Demonstrates basic communication and counseling skills.

1. Exhibits supportive interpersonal skills (i.e. attending, listening, showing empathy, prompting, summarizing, responding to feeling and content)
2. Establishes and maintains productive relationships with children/youth experience serious emotional and behavioral problems and their families
3. Provides assistance in decision-making and problem solving
4. Identifies and reinforces children, youth, and family skills, strengths, resources, and preferences
5. Recognizes behavioral dynamics in relationships
6. Recognizes the multiple ways in which children and youth and family needs may be expressed
7. Assists children/youth and their families to recognize patterns of behavior
8. Helps children/youth and their families develop effective strategies for managing internal and external stressors

9. Exhibits ability to negotiate conflict and mediate differences

B. Demonstrates ability to teach simple and complex skills including physical, social, intellectual , emotional skills

1. Managing behaviors
2. Maintaining education involvement
3. Accessing community resources
4. Building personal support and friendship networks
5. Performing daily living activities (Shopping, cooking, banking, etc.)
6. Managing symptoms and using coping skills
7. Relaxing and managing stress
8. Finding and maintaining recreation, leisure, and social activities
9. Finding and maintaining housing

C. Demonstrates understanding of a variety of program models and philosophies

1. Care coordination and case management
2. Family-centered in-home support services
3. Outpatient psychotherapeutic interventions (home, school, community, clinic)
4. Family support and respite
5. Mentorship
6. Technical/vocational education and training
7. Crisis intervention
8. Varied education approaches
9. School-based services

D. Demonstrates knowledge of a range of crisis prevention and intervention approaches.

1. Components of wellness
2. Crisis planning and prevention
3. Risk assessment
4. Crisis intervention and support alternatives
5. Hospital, residential, and judiciary diversion
6. Crisis recovery
7. Basic elements regarding emergency commitment, hospitalization, approvals by Panel regarding community-based services

E. Demonstrates knowledge and skill in evaluating and treating problems associated with substance abuse in children and adolescents

1. Understands the biopsychosocial impact of these conditions on the child or youth and family
2. Understands the range of treatment options and is able to make appropriate referrals

VI. DEMONSTRATES ABILITY TO DESIGN, DELIVER, AND ENSURE HIGHLY INDIVIDUALIZED SERVICES AND SUPPORTS.

A. Routinely solicits personal goals and preferences.

1. Helps child/youth and family identify personal preferences
2. Provides accurate information regarding options
3. Assists child/youth and family explore options and consequences of various choices
4. Facilitates and supports self-advocacy empowerment

B. Designs individualized wraparound service plans which provide the "best fit" regarding the needs and preferences of the child/youth and family.

1. Integrates child/youth and family choices into service plans
2. Builds upon child/youth and family strengths, resources, and abilities
3. Helps child/youth and family to evaluate the plans success and "fit" over time
4. Makes changes in plans to accommodate new learning and changes in preferences or needs
5. Recognizes importance of creative, non-traditional approaches to services
6. Advocates for services and resources which meet specific needs
7. Utilizes creative strategies that effectively support the development of critical social, living and thinking skills
8. Demonstrates patience and tenacity in designing and delivering individualized services/supports
9. Includes effective contingency planning in the service plan
10. Understands and effectively implements outcome-based service delivery

C. Encourages and facilitates personal growth and development toward maturation and wellness.

1. Helps children/youth and their families develop a vision of a positive personal future
2. Helps children/youth and their families identify practical strategies for achieving goals
3. Reinforces wellness

D. Facilitates and supports natural support networks.

1. Assists children/youth and families identify and connect with personal supports
2. Recognizes the value of peer support
3. Helps children/youth and families expand and strengthen personal support networks
4. Advocates for social inclusion and integration
5. Demonstrates ability to mediate conflicts

VII. WORKS IN COOPERATIVE AND COLLABORATIVE MANNER AS A TEAM MEMBER (AGENCY TEAMS, INTERAGENCY TEAMS, FAMILY MEMBERS, SERVICE RECIPIENTS, FOSTER PARENTS, CONCERNED OTHERS).

A. Coordinates service and support activities with others.

1. Utilizes the treatment team to develop service plans and build consensus for important decisions
2. Includes the full range of relevant people in decision making
3. Communicates information efficiently and accurately

B. Assists in building positive team relationships.

1. Solicits, accepts, and provides consultation and feedback
2. Negotiates differences
3. Supports other team members
4. Contributes to positive team morale
5. Seeks out and provides support for peers

C. Demonstrates fundamental collaborative skills

1. Able to define one's domain regarding knowledge base and skills
2. Respects the competencies, limitations, and contributions of other disciplines, individual professionals, workers, families, and children and youth
3. Recognizes situations where professional role diffusion may be appropriate
4. Communicates with colleagues in a nondefensive manner
5. Negotiates therapeutic roles in the manner most effective for the child and family

VIII. DEMONSTRATES KNOWLEDGE REGARDING THE RANGE OF SERVICE SYSTEM OPTIONS FOR CHILDREN/YOUTH WITH SERIOUS EMOTIONAL AND BEHAVIORAL PROBLEMS AND THEIR FAMILIES.

A. Identifies and accesses wide range of community resources.

1. Mental health services
2. Educational services
3. Social services
4. Probation and juvenile justice services
5. Health and public health services
6. Substance abuse services
7. Other community, vocational, social, civic, legal, housing, and medical resources

8. Self-help and advocacy organizations
9. Individual community members
10. Businesses and organizations
11. Recreational opportunities and resources
12. Spiritual and religious resources
13. Artistic and creative programs and resources

B. Develops and maintains good relationships with community representatives.

1. Skilled in collaboration
2. Demonstrates solid communication skills
3. Has effective time management skills
4. Demonstrates effective facilitation, mediation, and conflict resolution skills

C. Demonstrates knowledge of entitlement and benefit programs.

1. Education programs
2. Social Security
3. Vocational rehabilitation and education
4. Social services
5. Housing subsidy programs
6. EPSDT, Medicaid, and other federal entitlement programs
7. Managed care organizations

D. Integrates community resources into service planning.

1. Identifies opportunities to substitute community resources and support for agency delivered support
2. Demonstrates sensitivity to community concerns and political dynamics

E. Participates in pubic education and overall advocacy.

1. Provides accurate information about serious social, emotional, and behavioral problems in children/youth, and on the effect on their families
2. Advocates for policies and procedures which respect children/youth and family rights and dignity

IX. DEMONSTRATES COMPETENT AND SENSITIVE CLINICAL, DIAGNOSTIC AND THERAPEUTIC SKILLS

A. Demonstrates ability to utilize standardized diagnostic approaches and rating instruments

B. Demonstrates ability to evaluate level of psychosocial/psychoeducational functioning in children and adolescents

C. Demonstrates multi-modal therapeutic skills sufficiently flexible to accommodate and integrate different paradigms and approaches

1. Biomedical
2. Developmental
3. Psychoeducational
4. Psychosocial
5. Rehabilitative (including social skills and independent living skills training

D. Demonstrates solid treatment planning skills

1. Able to integrate diagnostic, functional, developmental, and environmental information into a coherent formulation and problem/strength list
2. Able to generate a relevant and effective plan of services, utilizing diverse therapeutic modalities and multi-disciplinary teams of professionals, paraprofessionals, and family members

E. Demonstrates solid consultative skills

1. Able to listen, develop clinical perspectives, and communicate in a sensitive and respectful manner
2. Able to coordinate services with professionals, paraprofessionals, and families
3. Able to facilitate others in effectively performing their roles and functions
4. Able to respect a system's organizational structure while managing clinical disagreements

F. Demonstrates system evaluation and intervention skills

1. Able to assess a system's organization and its resistance to conflicts
2. Able to devise effective interventions for system improvement (policy change, education, communication)

G. Demonstrates administrative skills

1. Role definition
2. Organization
3. Delegation
4. Communication
5. Conflict resolution

H. Demonstrates ability to define, measure, and maintain quality

1. Able to use quality assurance and quality management tools and processes
2. Able to communicate effectively with frontline service staff, families, and children and youth to determined if programs, services, and providers are sensitive, respectful, and effective

X. DEMONSTRATES KNOWLEDGE OF THE LEGAL SYSTEM AND INDIVIDUAL CIVIL RIGHTS.

A. Demonstrates knowledge of legal system.

1. Civil laws and court procedures
2. Juvenile justice laws and procedures
3. Children's Court procedures
4. Advocacy organizations and resources

B. Demonstrates knowledge of individual rights.

1. Confidentiality
2. Civil rights
3. Rights as a service recipient
4. Rights as a research participant

C. Connects individuals to legal and advocacy resources as needed and/or requested.

XI. CONDUCTS ALL ACTIVITIES IN A PROFESSIONAL MANNER.

A. Adheres to recognized ethical standards.

1. Recognizes ethical guidelines for community support work
2. Evaluates relationships and interventions according to ethical standards
3. Solicits feedback from others on any questionable behavior or intervention

B. Performs work in as positive manner.

1. Provides necessary support, mediation, and intervention activities, regardless of personal biases and attitudes
2. Demonstrates creativity in work activities
3. Demonstrates tenacity in work activities

XII. PURSUES PROFESSIONAL GROWTH AND DEVELOPMENT.

A. Seeks out learning opportunities.

1. Supervision
2. Peer support and supervision
3. Inservice training activities
4. Professional and filed-related literature

5. Conferences and other training events

B. Evaluates work effectiveness.

1. Supervisory and collegial feedback
2. Customer/consumer feedback
3. Collateral feedback

C. Integrates new learning into daily work practices.

1. Assessment process
2. Data gathering

Appendix C

PENNSYLVANIA CASSP TRAINING AND TECHNICAL ASSISTANCE INSTITUTE
SUMMARY OF CHILD, FAMILY AND COMMUNITY CORE COMPETENCIES

REVISED DRAFT
SUMMARIES OF CHILD, FAMILY AND COMMUNITY CORE COMPETENCIES

100 -- Child Competencies

The following overview specifies competencies for professionals providing services to children within CASSP. The competencies are addressed within seven specific age groups: 0-2, 3-5, 6-8, 9-11, 12-14, 15-17, 18-20.

1. Professionals will be able to view the child and family from the perspective of the child.

2. Professionals will be familiar with developmental expectations for children within the social, emotional, cognitive and physical domains.

3. Professionals will be able to recognize when children's behavior exceeds the range of "normal variability/expectation" within these domains.

4. Professionals will know how to conduct informal assessments of functioning within these domains and how to use information provided by formal assessments of these domains.

5. Professionals will know how and when to intervene to address behavior of concern to the parent and or child.

6. Professionals will recognize the range of mental health problems and be able to institute appropriate and effective interventions and referrals.

7. Professionals will have knowledge of and be sensitive to cultural strengths and differences.

8. Professionals will be able to implement services that incorporate cultural strengths.

9. Professional will demonstrate their cultural sensitivity in their interactions with children, and families.

10. Professionals will be aware of specific risks to children -- biological, psychological and sociocultural -- and be able to identify the severity of these risks with specific families and children.

11. Professionals will be familiar with current psychiatric diagnostic criteria and the etiology and frequency of childhood disorders including severe psychiatric disorders.

12. Professionals will be able to use this knowledge of psychiatric diagnosis in their work with specific children and families and be able to individualize and personalize their approach.

13. Professionals will be familiar with professionally recognized and current practices for work with children and families and be able to implement these approaches appropriately.

14. Professionals will identify and use interventions that are compatible with the culture of children and families.

15. Professionals will know professional standards of conduct and specific concerns within these standards that apply to children.

16. Professionals will have skills to communicate and document their assessments and interventions.

17. Professionals will be able to recognize children in crisis and intervene appropriately and effectively in an manner that includes the family as partners.

18. Professionals will be able to identify the least restrictive and intrusive service and intervene in a manner that incorporates this awareness.

200 -- Family Competencies

Professionals who provide services to children within the context of CASSP are required to address the parent-professional partnership in a respectful and competent manner. Therefore, professionals are expected to demonstrate skills and knowledge in the following areas:

1. Professionals will be familiar with the functions of a family and the potential impact and mutual influences of a child's emotional concerns and mental health problems on these functions.

2. Professionals will be familiar with the characteristics of the family, including structure, organization, dynamics, development and functioning.

3. Professionals will be familiar with the experiences and needs of families that have a child with a specific concern or disorder, including severe psychiatric disorders.

4. Professionals will be familiar with family risk factors, including life events within the family, life events in the social cultural context and difficulties in the family and extended family system.

5. Professionals will possess fundamental family assessment skills including the ability to prioritize, identify strengths, establish partnership in the assessment process and recognize the multiple characteristics of individual families including cultural factors.

6. Professionals will possess fundamental family intervention skills, including contacting the family, connecting with the family, establishing a treatment contract, helping the family meet their needs and helping the family develop adaptive patterns of functioning.

7. Professionals will be able to provide services in a culturally respectful manner.

8. Professional will be able to intervene to prevent crisis and to intervene when crises occur.

9. Professionals will be able to provide appropriate referral and collaboration.

10. Professionals will be able to address issues involved with medication appropriately.

11. Professionals will be able to provide collateral and collaborative family counseling in an appropriate and professionally sound manner.

12. Professionals will be able to intervene with couples and refer when appropriate.

13. Professionals will be aware of professional codes of ethics and conduct and be able to behave in a professional manner consistent with these codes.

300 -- Community Competencies

Professionals providing services within CASSP need specific knowledge and skills for community-based, interagency service delivery. The following area of competency are identified:

1. Professionals will be knowledgeable about formal government systems.

2. Professionals will be knowledgeable of other formal community and private child- and family-serving systems.

3. Professionals will have the ability to describe the range of mental health systems of care.

4. Professionals will have the ability to describe and recognize differences in community mental health, private sector provision, and facility-based services.

5. Professionals will have the ability to develop a county/regional profile.

6. Professionals will have the ability to assist families in the use of appropriate services.

7. Professionals will have the ability to engage and maintain collaboration with formal and informal systems and resources.

8. Professionals will have the ability to collaborate with families in accessing the least restrictive and least intrusive interventions and services.

9. Professionals will have the ability to identify cultural strengths in a community and intervene in a culturally competent manner from the perspective of the child's community.

10. Professionals will have the ability to identify the child's and family's perspective of community.

11. Professionals will have the ability to assist the family to be effective advocates for themselves and their child in multiple systems.

Appendix D

TRAIN THE TRAINERS ON CULTURAL COMPETENCE
NATIONAL TECHNICAL ASSISTANCE CENTER
FOR CHILDREN'S MENTAL HEALTH
GEORGETOWN UNIVERSITY CHILD DEVELOPMENT CENTER

Brief Overview of Descriptions

A-1 Introduction to Cultural Competence: This course will prepare trainers to plan and deliver training to providers using the cultural competence model. Participants will examine and discuss methods for influencing cross cultural attitudes and beliefs, and learn to communicate cultural competency information in a workshop setting.

A-2 Interface of Managed Care and Cultural Competence: This course will provide trainers and non-trainers with an introduction to managed care principles and practices from the perspective of people of color. The course will help participants to develop a better understanding of the socio-historical context for managed care and cultural competence as interrelated concepts.

A-3 Effective Strategies for Planning and Deliver Cultural Competence Training: This course will provide participants with tools and techniques that can be used to plan and deliver effective training in cultural competence. Each participant will be required to develop and present an instructional unit during this session.

A-4 Planning and Implementing Culturally Competent Services Evaluation: This course will provide a culturally competent, user-friendly approach to services evaluation that is designed to improve service delivery. Each participant will be introduced to planning and evaluation, developing a program model, and preparing an evaluation report.

B-5 Cultural Competence: An Intra-System and Inter-System Imperative: This interactive course will explore issues and approaches to infuse, integrate and institutionalize cultural competence principles and practices within and across agencies in a system of care.

B-6 Cultural Competence as a Systems Change Process: This session is designed to initiate thinking on the part of the participants regarding their role as change agents with respect to cultural competence as a systems change process, and will bring out the rewards and challenges of taking on the role.

B-7 The Cultural Context of Families of Children with Mental Health Issues: This course will explore how elements of race, economics, and religion impact services and supports. This course will also help participants to develop a better understanding of how to recognize culturally competent services.

C-8 Operationalizing Cultural Competency Standards in a Managed Care Environment: This course is for individuals who have had some experience in the managed care environment. This course will focus on the national CMHS standards on cultural competency and managed care and examine local and state implementation of these standards.

C-9 Cultural Competency Skills for Recruitment, Retention, and Supervision of a Diverse Workforce: This course will provide instructions to participants in applying the principles of cultural competence in management, recruitment, and supervision. Successful management strategies for negotiating barriers to recruitment, retention, and supervision will also be discussed.

C-10 Organizational Cultural Competence Self-Assessment: This course will provide information on how cultural competence self-assessment can enable organizations to examine existing conditions, operations, and procedures.

C-11 Outcomes and Systems Accountability: This course focuses on the development of outcomes and systems accountability toward the goal of improving cultural competence planning and service delivery.

C-12 Effectively Managing Intercultural Conflict: This course will help professionals explore culturally diverse perspectives regarding problem solving, communication styles, and cross cultural misunderstandings. Effective methods of managing conflict that can arise from multicultural interaction will be highlighted.

C-13 Clinical/Cultural Paradigm Shifts: Helping Clinicians Rethink Theory for Cultural Competence: Using the concept of paradigm shifts, this course will help participants to understand the impact of cultural differences on human behavior.

C-14 Family Strategies for Negotiating with Unresponsive Institutions: This course will help participants to understand family experiences with and expectations of community institutions, and highlight family strategies for negotiating unresponsive organizations.

C-15 Using Strategic Planning to Implement Cultural Competence: This course will help participants understand the concept of strategic decision making and how it can be used to implement cultural competence. Examples will be provided.

C-16 Implementing Cultural Competence in Community-Based Systems of Care: This course will help provide participants with an understanding of what cultural competence looks like in a community context and help them identify the external and internal community dynamics that must be addressed to work effectively in systems of care at the community level.

Appendix E

SANTA BARBARA, CALIFORNIA
MULTIAGENCY INTEGRATED SYSTEM OF CARE
SAMPLE CROSS-SYSTEM INTERAGENCY TRAINING SCHEDULE FOR THE CROSS-SYSTEM ORIENTATION, TRAINING AND TEAM BUILDING OF CHILD-SERVING STAFF.

Day 1

9:00 am - 10:30	Welcome and introduction to cross-systems orientation, training, and team building
	History of interagency partnerships
	Individual introductions
	Ground rules, trust, and safety regarding expression of feelings
	Expectations regarding training and team building (group brainstorming)
	* "As trenchworkers, what do you need to do your job well?"
	* "What can this training do to best support you?"
10:30-10:45	Break
10:45-12:00	Why work collaboratively with families and agencies: Point/Counterpoint
	System Introduction/Goals of Project
	* partnership with families
	* target population
	* strengths-based, ecological, and holistic emphasis
	* outcome-based service delivery utilizing comprehensive assessment and evaluation and ongoing monitoring
	* review of specific components re: agency collaboration, with focus on *practical* and *real* enhancements that collaboration can offer
	Cooperation vs. Collaboration
	Review of "Workforce Competencies"
12:00-1:00 pm	Lunch in small groups, discussing "baggage"
1:00-2:15	Group process exercise
	Review of "the System": What works, what doesn't (small group)
	Summary and questions
2:15-2:30	Break

2:30-4:00	Guiding principles: discussion and reframing
4:00-4:30	Questions and summary, closure activity

Day 2

9:00 am - 10:00	Group process exercise for individual introductions
	Family-centered service delivery
	* steps for building effective partnerships
	* strengths-based approach
	* respect for natural support systems
	* family involvement/perspective
	* parental input on strength and needs
	* what works best
10:00-10:15	Break
10:15-12:00	Panel discussion with family members
	* experiences with "the System"
	* what works, what doesn't
	* personal expectations of family members
	Summary and questions
12:00-1:00 pm	Lunch with job partner
1:30-4:30	Cross-system job shadowing
	* tour of facilities
	* goals and expectations regarding the position
	* barriers
	* individual successes and accomplishments

Day 3

9:00 am - 10:30	Review of job shadowing experience
	Introduction of partners
	* "I used to think his/her job was..."
	* "Now I know that his/her job is..."
	* "I was most impressed by..."
10:30-10:45	Break
10:45-12:00	Overview of partner agencies and "system realities"
	* definitions, language, and terminology
	* jargon and acronyms

* protocol
* agency-specific mandates of PSD/Probation (legal responsibility,
* court reporting of suspected abuse, investigation requirements, etc.)

12:00-1:00 pm Lunch with small group

1:00-2:30 Energizer

Day-to-Day Administrative Realities

* job descriptions for community-based staff
* confidentiality
* lines of authority
* site manager's role
* supervision: on site and off site
* departmental vs. interagency responsibilities
* forms
* service and assessment approval
* documentation (Medical, billing)
* work locations and office hours

2:30-2:45 Break

2:45-4:00 Changing Roles (small group process)

* roles of agency staff on an interagency team (PSD, Probation, MH, PH Nursing, Drug & Alcohol, schools, non-profit orgs.)
* guidelines for traditional caseload duties, and how they fit into new interagency expectations
* supervision and support: best practices
* family and community partnerships

4:00-4:30 Review and Discussion, Questions

Day 4

9:00 am 10:30 Energizer

A Cycle of Failure: understanding stress life events

* dynamics of abuse (attachment problems, post traumatic stress disorder (PTSD)
* impact of loss, out of home placement, homelessness, and having parents with mental illnesses
* unique needs of adolescents and serious emotional disturbance (who may also be parents) effects of abuse/neglect on

	* child development
10:30-10:45	Break
10:45-12:00	Service planning exercise: development of individualized "universal" family service plan based on identified needs (small group process, large group review and discussion)
	Description of fieldwork and assignments
12:00 pm-1:00	Lunch with small group
1:30-4:30	Fieldwork
	* review goals of fieldwork
	* do site visit
	* process: "lessons learned"
	* plan report to large group

Day 5

9:00 am 10:00	Energizer
	Review of Fieldwork
	* identified symptoms
	* what works best
	* critical needs
10:00-10:15	Break
10:15-12:00	Interface with the Schools
	* realities in the classroom
	* expectations: "Can/should schools be all-knowing, all-providing?
	* roles and responsibilities
	* types of educational settings
	* range of programs and services
	* school districts procedures and legal requirements
	* best practices regarding communication, planning, and support
	Small group discussion: "How do we best collaborate with the schools?"
12:00 pm-1:00	Lunch with small group
1:00-2:15	Creative Service Options and Community Resources
	* list natural supports and informal/formal community resources
	* develop continuum of service, from prevention to placement
	* using case vignette, strategize effective means of re-integration into community from out-of-county placement
2:15-2:30	Break

2:30-4:30	Development of service plan, charting, and progress notes
	* goals
	* legal requirements
	* specific departmental expectations
	* best practices
	Summary and processing

Day 6

9:00 am 10:30	Energizer
	Service Planning
	* writing goals/objectives
	* Wraparound philosophy
	* developing transition plans
	* coordinating services
	* gaining approval for service delivery
	* contacting the school district
10:30-10:45	Break
10:45-12:00	Assessment Philosophy and Process
	Review of "Core Competencies"
	* review and discuss (small group)
	* develop plan/picture for describing competencies to larger audience
	* group discussion/presentation
12:00 pm-1:00	Lunch with small group
1:00-3:15	Cross-systems service delivery: planning and program development exercise
	* develop context of problem
	* develop vision statement for effective family-centered and community-based solution to identified problem
	* identify existing strengths and barriers
	* develop action plan
	* identify outcomes that can benchmark the effectiveness of the implementation of the action-plan
	* prepare plan for presentation to larger group
3:15-3:30	Break
3:30-4:30	Summary of experiences
	Questions and comments
	Closure exercise